NEW DIMENSIONS IN EMERGENCY HEALTH SERVICES:

an Alberta Solution

a report by the Policy Advisory Committee to the
Minister of Alberta Hospitals and Medical Care

88-04313/

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May, 1988

INTRODUCTION

Introduction

On February 5, 1987, the Policy Advisory Committee to the Minister of Hospitals and Medical Care was assigned the task of examining all aspects of the ambulance services system in Alberta and making recommendations to the Minister of Hospitals and Medical Care. In order to complete this task, the Committee focused its review process on public hearings and oral and written submissions. The purpose of this public approach was to gather relevant and appropriate information from those involved in ambulance service, and to assess the strengths and weaknesses of the current system.

During the course of this comprehensive review, it became clear to the Policy Advisory Committee that a broader look, beyond the ambulance service system and into emergency health care services, was needed. The Committee, with ministerial sanction, extended its mandate to encompass emergency health care services as these services relate to the health care delivery system.

Its review completed, the Committee recommends the purpose of the Emergency Health Care Service System be:

> **To provide the ill or injured with an emergency service which is an integral part of the health care delivery system and has as its primary mandate: 'Pre-hospital care with appropriate and timely medical transportation within the scope of a locally managed, provincially standardized, co-ordinated, multi-tiered, comprehensive system which can effectively and efficiently meet the needs of Albertans.'**

Acknowledgements

Members of the public and representatives from throughout the ambulance industry and the emergency health care field devoted a great deal of thought and effort, individually or through their organizations, to providing written and oral presentations to the Policy Advisory Committee to the Minister of Hospitals and Medical Care. For this, the Committee is deeply indebted.

Thanks are also expressed for the support and assistance of officials from government emergency medical services in British Columbia, Saskatchewan, Manitoba and Ontario, who readily shared knowledge of their provincial ambulance systems.

In addition, personnel from Alberta Hospitals and Medical Care served as a constant source of information and support during the study and in the preparation of this report.

In the Committee's view, the assistance and interest shown by so many individuals and organizations demonstrates the importance Albertans place on ambulance services. This interest also indicates a true desire to ensure that the best possible ambulance system is developed to meet the needs of the people of this province.

It is with sincere appreciation that the Committee extends recognition to all those individuals who participated in this review of Alberta's Ambulance System.

The Policy Advisory Committee to the Minister of Hospitals and Medical Care is comprised of:

Mr. Stan Schumacher, MLA (Drumheller), Chairman
Mr. Halvar Jonson, MLA (Ponoka), Vice-Chairman
Mr. Jim Cawsey (Drumheller)
Mrs. Adelaide Davis (Medicine Hat)
Mrs. Iris Evans (Sherwood Park)
Ms. Susan Green (Edmonton)
Mr. Gerry Hachey (Falher)
Mr. Ken Mark (Spruce Grove)
Mr. Doug Tien (Camrose)
Mr. Sid Wallace (Calgary)
Mrs. Nomi Whalen (Calgary)
Ms. Lucille Krys, Recording Secretary

RECOMMENDATIONS

RECOMMENDATIONS

Legislative Framework

RECOMMENDATION 1 — **THAT** an Emergency Health Services Act be established, covering all aspects of ambulance services.

Jurisdiction

RECOMMENDATION 2 — **THAT** a provincial Emergency Health Services Commission be established.[1]

RECOMMENDATION 3 — **THAT** an advisory board, reporting to the Minister of Hospitals and Medical Care and representing consumers and providers of Emergency Health Services in Alberta, be appointed with a mandate to advise the Minister on policy direction, and advise the Commission on the integration and co-ordination of the Emergency Health Services system.

RECOMMENDATION 4 — **THAT** the establishment and operation of a local ground ambulance service at a minimum level of Basic Life Support[2] be the responsibility of municipal governments.

RECOMMENDATION 5 — **THAT** local authorities may exceed the minimum Basic Life Support level of service should local support and resources be available.

RECOMMENDATION 6 — **THAT** municipal governments, hospital boards and other emergency service agencies be encouraged to work with neighboring jurisdictions to fulfil the mandate of providing quality ambulance services, and that procedures be established for sharing services across ambulance service area boundaries in times of major emergencies or in other special circumstances.

RECOMMENDATION 7 — **THAT** ambulance service area boundaries be established, but when local authorities are unable to establish ambulance service area boundaries, the Commission would assume responsibility for the establishment of such boundaries.

RECOMMENDATION 8 — **THAT**, as a general guideline, in jurisdictions supported by a population base of less than 3,000 persons, joint agreements to provide ambulance services with neighboring jurisdictions be a condition of receiving provincial funding.

Management Information Systems

RECOMMENDATION 9 — **THAT** a universal and comprehensive management information system be developed and implemented.

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[1] See Appendix 3 for proposed Organization Chart.

[2] Basic Life Support (BLS) is an ambulance service which provides personnel qualified to the Emergency Medical Technician — Ambulance level and registered by the Health Disciplines Board, along with the necessary equipment and communications network to support the role. The term also refers to personnel qualifications for this level of service.

Standards

RECOMMENDATION 10 — **THAT** Basic Life Support be established as the minimum level of ambulance service throughout Alberta.

RECOMMENDATION 11 — **THAT** provincial standards for equipment, vehicles and aircraft be consistent with the establishment of a Basic Life Support level of ambulance service.

RECOMMENDATION 12 — **THAT** a system of certification, including ongoing evaluation and inspection of ambulance services, be established and maintained.

RECOMMENDATION 13 — **THAT** First Responder Teams[1] be approved by the Commission and developed to support a Basic Life Support system in certain isolated or sparsely populated areas or where response times warrant.

RECOMMENDATION 14 — **THAT** a provincial system of emergency medical care protocols[2] be established and maintained with the assistance of medical advisors.

RECOMMENDATION 15 — **THAT**, as a minimum standard, all persons involved in driving ambulances must have successfully completed courses in advanced first aid, CPR and defensive driving.

RECOMMENDATION 16 — **THAT** Basic Life Support be the minimum qualification of provincial dispatch personnel.

RECOMMENDATION 17 — **THAT** Basic Life Support be the minimum standard for personnel accompanying patients being transferred by air ambulance, with the appropriate further qualifications as set down by provincial protocols.

RECOMMENDATION 18 — **THAT**, in recognition of the role Registered Nurses (RNs) could play in pre-hospital care, the Committee recommends that the Health Disciplines Board develop the appropriate additional qualifications which would allow for the certification of Registered Nurses as Emergency Medical Technicians — Ambulance and Emergency Medical Technicians — Paramedic.

RECOMMENDATION 19 — **THAT** the Health Disciplines Act be amended to require that all Emergency Medical Technicians operating as ambulance attendants be registered with the Health Disciplines Board.

Personnel and Training

RECOMMENDATION 20 — **THAT** educational institutions presently involved with training be encouraged to work co-operatively in the development of a standardized curriculum for basic training and continuing education.

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[1] First Responders are persons trained to the St. John's modular course or its equivalent advanced first aid and CPR courses. These individuals would be used in an Emergency Health Services system in the stabilization of patients, while being integrated with a BLS service in remote and isolated areas of the province.

[2] Protocols are an established set of procedures used to carry out specific actions. Protocols have been applied in the Emergency Medical Services industry to all operational activity, including personnel activity, medical supervision, inspections of equipment and vehicles, and communications.

RECOMMENDATION 21 **THAT** educational institutions be invited to prepare proposals to meet the inservice and skill maintenance needs of Emergency Medical Technicians.

RECOMMENDATION 22 **THAT** programs for inservice and skill maintenance for Emergency Medical Technicians be more readily accessible throughout the province.

RECOMMENDATION 23 **THAT** specific training programs for provincial dispatchers be established.

RECOMMENDATION 24 **THAT** certification as an Emergency Medical Technician be dependent upon successful completion of a provincially set examination.

RECOMMENDATION 25 **THAT** future personnel and training needs be determined to assist in planning educational requirements.

Communications System

RECOMMENDATION 26 **THAT** a province-wide communication system be established which would create an effective network for the ambulance system.

RECOMMENDATION 27 **THAT** a central dispatch system for air and ground ambulance be established in the technically most effective location.

RECOMMENDATION 28 **THAT** a common call number (911) be established for public access to the system across the province.

RECOMMENDATION 29 **THAT** a system for setting the medical priority of cases be established and used in the dispatch of equipment and personnel.

RECOMMENDATION 30 **THAT** bed registries and emergency room status reports be established by hospitals in major centres to enable central dispatch to co-ordinate emergency ambulance services.

Revenues and Costs

RECOMMENDATION 31 **THAT** a minimum co-insurance charge be established by the Commission for both air and ground ambulance service when medical transportation is required prior to hospitalization.

RECOMMENDATION 32 **THAT** a per capita operational grant, determined on a formula basis, be provided to local authorities to support Basic Life Support service.

RECOMMENDATION 33 **THAT** lottery funds be used for one-time, start-up grants for capital upgrading, to be provided on application to the Commission for assistance in the establishment of Basic Life Support service.

RECOMMENDATION 34 **THAT** the province bear the cost of establishing and operating the central ambulance communications system.

RECOMMENDATION 35 **THAT** the Emergency Health Services Commission be asked to develop a funding system for medical transportation to ensure that the most cost-effective, medically appropriate mode of transportation is used.

Interhospital and Interprovincial Transfers

RECOMMENDATION 36 **THAT** interhospital transfers, appropriate to the medical condition of the patient, be scheduled through central dispatch.

RECOMMENDATION 37 **THAT** commercial transportation be used, where medically appropriate, for interhospital transfers.

RECOMMENDATION 38 **THAT** outpatients no longer be charged, beyond an initial co-insurance fee, for ambulance service deemed medically required for transfer.

RECOMMENDATION 39 **THAT** guidelines for interprovincial ambulance service be set through the Commission.

Air Ambulance

RECOMMENDATION 40 **THAT** strict guidelines, set by the Commission, be applied to the use of fixed and rotary wing aircraft.

RECOMMENDATION 41 **THAT** a registry of qualified aircraft operators be maintained.

NOTE: Other recommendations directly affecting air ambulance include Recommendations 1, 2, 3, 4, 9, 11, 17, 26, 27, 31, 35, 36, 37, 38, 39.

RECOMMENDATIONS AND RATIONALE

Legislative Framework

RECOMMENDATION 1

THAT an Emergency Health Services Act be established, covering all aspects of ambulance services.

RATIONALE:

Alberta currently does not have adequate legislation to deal effectively with issues and opportunities involved in improving ambulance service delivery. Various aspects of ambulance services are controlled by five separate Acts.

An Emergency Health Services Act would provide provincial identity and status to ambulance services as part of the health care delivery system, and would bring co-ordination and direction to air and ground ambulance services.

To complete the process of establishing an act references to ambulance service in the Municipal Government Act would be deleted and references to the Highway Traffic Act and the Health Disciplines Act would have to be included.

Jurisdiction

RECOMMENDATION 2

THAT a provincial Emergency Health Services Commission be established.[1]

RATIONALE:

Alberta currently has no umbrella group charged with the management of the ambulance system. Consequently, a void exists in areas of responsibility and authority to set objectives, set standards, define roles, evaluate performance, implement corrective action, monitor maintenance activity, establish appropriate fee levies, and regulate and license personnel, vehicles, and equipment. A Commission would provide the provincial government with an effective vehicle to implement and manage new legislation, as well as allowing for greater participation in Emergency Health Services. The establishment of a Commission would provide a higher profile for Emergency Health Services.

RECOMMENDATION 3

THAT an advisory board, reporting to the Minister of Hospitals and Medical Care and representing consumers and providers of Emergency Health Services in Alberta, be appointed with a mandate to advise the Minister on policy direction, and advise the Commission on the integration and co-ordination of the Emergency Health Services system.

RATIONALE:

The Policy Advisory Committee believes the assembly of an advisory board from the ambulance industry, the medical and educational fields, and the public would benefit both the Minister and the Commission with the expertise and broad understanding of the emergency health services that are required to integrate and co-ordinate such a system in Alberta.

[1] See Appendix 3 for proposed Organization Chart.

RECOMMENDATION 4

THAT the establishment and operation of a local ground ambulance service at a minimum level of Basic Life Support[1] be the responsibility of municipal governments.

RATIONALE:

The majority of municipal governments currently control the delivery of ambulance services in their respective communities. This decentralized approach to a province-wide ambulance system reflects the belief in local autonomy within provincial guidelines, which has been effective in meeting specific local needs and should continue to be encouraged. While a small minority of municipal governments has not accepted the responsibility of establishing and providing ambulance services as part of the governing mandates, in future all municipalities will have to do so.

It is the Committee's considered opinion that, to ensure the appropriate pre-hospital care in all areas of the province, Basic Life Support should be the minimum level of ambulance service. Basic Life Support is widely accepted by other provincial jurisdictions as the minimum level of personnel training for effective ambulance services and was overwhelmingly supported during representation to the Policy Advisory Committee. The implementation of this minimum level of service is also practical because the majority of ambulance services throughout the province currently operates with personnel qualified at least to Basic Life Support.

RECOMMENDATION 5

THAT local authorities may exceed the minimum Basic Life Support level of service should local support and resources be available.

RATIONALE:

Alberta has qualified paramedics serving nearly half of the province's population. This situation is applauded, and also recognized as one benefit of local autonomy in that advanced services in emergency health care can be developed when warranted.

RECOMMENDATION 6

THAT municipal governments, hospital boards and other emergency service agencies be encouraged to work with neighboring jurisdictions to fulfil the mandate of providing quality ambulance services, and that procedures be established for sharing services across ambulance service area boundaries in times of major emergencies or in other special circumstances.

RATIONALE:

Economies of scale dictate that it is appropriate for neighboring jurisdictions to co-operate with one another to develop and ensure the effectiveness of ambulance services provided to their citizenry.

The co-ordination of services in major emergencies is essential. Procedures and plans to cope with such emergencies have been prepared by all levels of government, and it is appropriate that procedures be added to identify methods of sharing ambulance services across service area boundaries.

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[1]Basic Life Support (BLS) is an ambulance service which provides personnel qualified to the Emergency Medical Technician — Ambulance level and registered by the Health Disciplines Board, along with the necessary equipment and communications network to support the role. The term also refers to personnel qualifications for this level of service.

RECOMMENDATION 7

THAT ambulance service area boundaries be established, but when local authorities are unable to establish ambulance service area boundaries, the Commission would assume responsibility for the establishment of such boundaries.

RATIONALE:

The responsibility for setting ambulance service area boundaries would be that of local authorities. Defined service area boundaries would assist in determining local responsibility for dispatching and financing ambulance service and should result in appropriate and equitable deployment of personnel and equipment. These boundaries would also assist the Commission in its planning by identifying possible gaps and overlaps in service. Given that a local authority or municipality were unable to establish these boundaries, however, the Commission, as the agent of the provincial government, should do so to ensure that all areas of the province are adequately serviced by ambulance.

RECOMMENDATION 8

THAT, as a general guideline, in jurisdictions supported by a population base of less than 3,000 persons, joint agreements to provide ambulance services with neighboring jurisdictions be a condition of receiving provincial funding.

RATIONALE:

In sparsely-populated areas, low call-volume results in higher costs for delivery of ambulance services. Compounding this economic concern is the effect of low call-volume on the maintenance of the emergency medical technicians' skills. Joint agreements between neighboring jurisdictions that are affected by low populations could assist in reducing costs for service delivery on a per patient basis and should provide sufficient activity for Emergency Medical Technicians to maintain their skills through experience.

Management Information Systems

RECOMMENDATION 9

THAT a universal and comprehensive management information system be developed and implemented.

RATIONALE:

Currently, the recording and monitoring of information with respect to ambulance services is inadequate. Although several provincial agencies are committed to providing direct or indirect funding for ambulance services, no comprehensive system is in place to ensure accountability or planning for change in the use of these funds. Efficiencies would be gained in the government funding structure through a continuous and accurate information-gathering process. In addition, transmission of patient and hospital information could result in more effective handling of emergency patients and potentially reduce their hospital stays. Other provinces have established management information systems successfully with a multi-part form which not only transmits information to all interested parties, but ensures confidentiality of patient information.

Standards

RECOMMENDATION 10 **THAT Basic Life Support be established as the minimum level of ambulance service throughout Alberta.**

RATIONALE: Basic Life Support provides a medically recognized minimum emergency medical care for ill or injured persons, and is currently the minimum standard for ambulance services in other provincial jurisdictions. This level of service is practical as a minimum standard, as the majority of ambulance services in Alberta operates with personnel qualified at least to Basic Life Support.

RECOMMENDATION 11 **THAT provincial standards for equipment, vehicles and aircraft be consistent with the establishment of a Basic Life Support level of ambulance service.**

RATIONALE: The maintenance of a Basic Life Support level of service requires that equipment, vehicles and aircraft complement the activities of the Emergency Medical Technician in the role of emergency care provider and that appropriate provincial standards be developed.

Historically, standards for aircraft and equipment used in air ambulance services have not been prescribed. However, the variations in type of aircraft and in their capability to maintain a consistent and medically beneficial environment, along with the aircraft's performance criteria, need to be addressed and standardized for the benefit of the patient and the medical escort team.

RECOMMENDATION 12 **THAT a system of certification, including ongoing evaluation and inspection of ambulance services, be established and maintained.**

RATIONALE: A comprehensive and rigorous system of certification, including evaluation and inspection of ambulance services, is not presently available in the province. Such a certification system would ensure ambulance services comply with government-determined performance standards and would provide a foundation for consistency and quality of ambulance service for all Albertans.

RECOMMENDATION 13 **THAT First Responder Teams[1] be approved by the Commission and developed to support a Basic Life Support system in certain isolated or sparsely populated areas or where response times warrant.**

RATIONALE: In areas where communities are located some distance from the ambulance service, in sparsely-populated, remote or isolated areas of the province with limited call-volume or in areas where response times warrant, First Responders under the direction of a Basic Life Support service would be ideal. To ensure delivery of emergency medical service in remote areas, the First Responder concept would be used to provide an initial, stabilizing level of care while Basic Life Support service is routed to the call site. The use of First Responders would not only serve to provide minimal emergency care, but would also lend recognition to the important role of volunteers in the emergency medical system.

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[1]First Responders are persons trained to the St. John's modular course or its equivalent advanced first aid and CPR courses. These individuals would be used in an Emergency Health Services system in the stabilization of patients, while being integrated with a BLS service in remote and isolated areas of the province.

RECOMMENDATION 14

THAT a provincial system of emergency medical care protocols[1] be established and maintained with the assistance of medical advisors.

RATIONALE:

Province-wide emergency medical care protocols would ensure that all Emergency Medical Technicians provide care at a consistent level in any circumstance. The provision of provincial protocols would overcome the difficulties experienced by small ambulance services in the development of their own protocols, yet should not compromise the autonomy of local groups to develop additional protocols. Provincial protocols would also provide a means for effective co-ordination, evaluation and standardization of care, and are legally important to protect care givers against liability.

RECOMMENDATION 15

THAT, as a minimum standard, all persons involved in driving ambulances must have successfully completed courses in advanced first aid, CPR and defensive driving.

RATIONALE:

Minimum training in the St. John's modular first aid program would increase effectiveness as part of a health care emergency team. Should a situation warrant their assistance, ambulance drivers with training in advanced first aid and CPR would be much better equipped to respond.

To assist in the delivery of emergency care, all ambulance drivers need to be aware of their responsibilities and should be trained to handle emergency vehicles in the safe transportation of the sick and injured.

Defensive-driver training should be required to promote safety habits and improve safe-driving performance.

RECOMMENDATION 16

THAT Basic Life Support be the minimum qualification of provincial dispatch personnel.

RATIONALE:

As dispatchers are often the first point of entry into the health care system, it is imperative that they be competent to assess and respond appropriately to the needs of ill or injured persons. A minimum training of Basic Life Support would provide dispatch personnel with the knowledge to critically evaluate requests for ambulance service.

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[1]Protocols are an established set of procedures used to carry out specific actions. Protocols have been applied in the Emergency Medical Services industry to all operational activity, including personnel activity, medical supervision, inspections of equipment and vehicles, and communications.

RECOMMENDATION 17

THAT Basic Life Support be the minimum standard for personnel accompanying patients being transferred by air ambulance, with the appropriate further qualifications as set down by provincial protocols.

RATIONALE:

The application of minimum standards for air ambulance service would ensure that patients are treated equitably in either air or ground ambulance environments. Since travel by air increases the potential impact of air pressure variations and oxygen needs on a patient's condition, the Basic Life Support minimum for air ambulance service would require upgrading to include the qualifications as defined by the Emergency Medical Technician Regulation, section 10(1) of the Health Disciplines Act. These criteria foster medical competency in air ambulance services and assist in maintaining the continuity of patient care throughout the health care system.

RECOMMENDATION 18

THAT, in recognition of the role Registered Nurses (RNs) could play in pre-hospital care, the Committee recommends that the Health Disciplines Board develop the appropriate additional qualifications which would allow for the certification of Registered Nurses as Emergency Medical Technicians — Ambulance and Emergency Medical Technicians — Paramedic.

RATIONALE:

Education, licensing and medical control of registered Emergency Medical Technicians — Ambulance and Paramedic — are addressed by the Health Disciplines Act.

However, RNs with Advanced Cardiac Life Support qualifications have not been considered by the Health Disciplines Act. Although the hospital is recognized as the community centre for health care, the effectiveness of its personnel has yet to be maximized in the delivery of trauma and emergency services. Registered Nurses with the appropriate further qualifications represent an opportunity to extend the role and effectiveness of these hospital personnel in emergency care. The benefits of using these specially qualified RNs in the delivery of emergency pre-hospital care would be realized in rural hospital areas where the availability of staff is limited.

RECOMMENDATION 19

THAT the Health Disciplines Act be amended to require that all Emergency Medical Technicians — Ambulance and Emergency Medical Technicians — Paramedic operating as ambulance attendants be registered with the Health Disciplines Board.

RATIONALE:

Established legislation does not have the mandate to regulate ambulance attendants who do not voluntarily register with the Health Disciplines Board.

The recommended changes to the Health Disciplines Act would ensure that all ambulance attendants are regulated to the same standards of training and performance, and would assure Albertans of receiving quality emergency health care anywhere in the province.

Personnel and Training

RECOMMENDATION 20 **THAT educational institutions presently involved with training be encouraged to work co-operatively in the development of a standardized curriculum for basic training and continuing education.**

RATIONALE: Training programs for emergency medical care personnel are provided at three separate colleges in the province. These programs were developed independently, giving cause for concern as to consistency in personnel training. Standardized training would ensure that the Basic Life Support minimum level of service is consistent throughout the province, and would provide Emergency Medical Technicians with educational qualifications appropriate to all local jurisdictions. Unique requirements in aeromedical emergency care would need to be addressed.

RECOMMENDATION 21 **THAT educational institutions be invited to prepare proposals to meet the inservice and skill maintenance needs of Emergency Medical Technicians.**

RATIONALE: Standardizing inservice and skill-maintenance programs for Emergency Medical Technicians would eliminate the possibility of inconsistencies among individual programs provided by the respective educational institutions. This unified approach would also upgrade all practising Emergency Medical Technicians to the same standard. For a full complement of training, the accepted program would have to incorporate the outreach concept to ensure that personnel in both urban and rural locations have similar access to program components.

RECOMMENDATION 22 **THAT programs for inservice and skill maintenance for Emergency Medical Technicians be more readily accessible throughout the province.**

RATIONALE: Rural Emergency Medical Technicians are currently disadvantaged in terms of availability of continuing education programs. Easier access to such programs would assist in continuity of care throughout the province.

RECOMMENDATION 23 **THAT specific training programs for provincial dispatchers be established.**

RATIONALE: Training for dispatchers at present is not standardized. Dispatchers need to understand the severity of injury or medical condition to respond with speed and accuracy in dispatching the most appropriate medical aid to an individual in distress. A Basic Life Support background must be combined with a thorough training in radio, telephone and communications technology to provide the dispatcher with the necessary skills for this critical emergency role. Training for dispatchers should follow graduation from a recognized Basic Life Support program and experience as an Emergency Medical Technician.

RECOMMENDATION 24 **THAT certification as an Emergency Medical Technician be dependent upon successful completion of a provincially set examination.**

RATIONALE: A provincial examination process for Emergency Medical Technician certification would ensure a uniformity of knowledge for all Emergency Medical Technicians and provide consistency in the administration of care.

RECOMMENDATION 25

THAT future personnel and training needs be determined to assist in planning educational requirements.

RATIONALE:

No projections exist as to the need for trained personnel to meet the demands of a province-wide Basic Life Support level of service. Such projections would be valuable to long-term personnel planning, ensuring the Emergency Medical Technician work-force is maintained at the required levels. Addressing future training needs would assist educational institutions in incorporating advances in emergency medical technology into their programs.

Communications System

RECOMMENDATION 26

THAT a province-wide communication system be established which would create an effective network for the ambulance system.

RATIONALE:

Widespread support for the establishment of a communications system was apparent from the responses to the questionnaires and in the public hearings. Available communications operations backing ambulance services in the province are both unco-ordinated and narrowly defined to meet the local need. These individual operations are unable to address the requirements of a province-wide emergency communications network. Other provinces, however, have successfully utilized technology for such a system. The capability to co-ordinate various emergency services by a province-wide communications system would ensure rapid response by appropriate agencies and would result in improved service effectiveness and manpower efficiencies. It is evident that an emergency service can only be as effective as its system of exchanging information.

The communication system should be compatible with, but not infringe upon, police, fire, hospital and other emergency-agency communications systems.

To maximize the effectiveness of a province-wide ambulance communication system, communications equipment in ambulance vehicles should be compatible with that of the dispatch centre. Standardization of ambulance radio equipment would ensure this communications capability throughout the province.

RECOMMENDATION 27

THAT a central dispatch system for air and ground ambulance be established in the technically most effective location.

RATIONALE:

A single dispatch system would have the advantage of improved co-ordination and long term economy, and has been proven capable, in other jurisdictions, of covering a wide geographic area. A combined air and ground ambulance dispatch centre would enable dispatchers to co-ordinate patient movement by both air and ground transportation modes and effectively reduce incidents of aircraft or ground ambulances returning without patients to base stations. Improved co-ordination through a combined dispatch centre would make more effective use of personnel and resources.

Considering the costs of air ambulance and inter hospital transfers, the phasing-in of the combined dispatch centre's operations should deal first with air ambulance, then with interhospital transfers.

On successful implementation of these dispatch procedures, the centre could then address ground ambulance dispatch needs. The Commission would have to determine the technical complexity and needs of dispatching to ensure improvements in patient transport.

RECOMMENDATION 28 **THAT a common call number (911) be established for public access to the system across the province.**

RATIONALE: Albertans frequently have difficulty accessing appropriate emergency services. Although 911 numbers have been established in Edmonton, Red Deer and Calgary, this service is not available throughout Alberta. Rapid access to emergency service dispatchers through a 911 number may be the most viable solution for rural Albertans in life-threatening situations.

The Committee recognizes that, although a common call number at this time may not be technically feasible, progress is being made in the development of such a number to cover all areas of the province.

RECOMMENDATION 29 **THAT a system for setting the medical priority of cases be established and used in the dispatch of equipment and personnel.**

RATIONALE: A system of categorizing patient cases would provide support to the management information system and allow for the measuring of ambulance service demand. A standardized system for determining ambulance case priorities has proven effective in Ontario and British Columbia.

RECOMMENDATION 30 **THAT bed registries and emergency room status reports be established by hospitals in major centres to enable central dispatch to co-ordinate emergency ambulance services.**

RATIONALE: Bed registries and emergency room status reports would encompass the provision of information, by hospitals to a central dispatch, indicating bed and staff availability in hospital departments and the capability for effecting patient treatment.

The establishment of such reports and their co-ordination by central dispatch would assure the appropriate entry of patients to health care facilities while increasing the efficiencies in the health care system.

Revenues and Costs

RECOMMENDATION 31 **THAT a minimum co-insurance charge be established by the Commission for both air and ground ambulance service when medical transportation is required prior to hospitalization.**

RATIONALE: A minimum co-insurance charge assigned to both air and ground ambulance service would require participation by the consumer and may deter service abuse. The responsibility for setting a maximum co-insurance charge for ground ambulance would rest with the local authority. Local governments may provide additional financial support, derived from their tax base, to the ambulance service to lower the minimum co-insurance charge in the municipality.

RECOMMENDATION 32 **THAT a per capita operational grant, determined on a formula basis, be provided to local authorities to support Basic Life Support service.**

RATIONALE: Recognizing the importance of ambulance services in the health care system, the province should provide direct funding to support Basic Life Support as a minimum level of service. The operational grant should be determined on a formula basis to compensate for the influence of geography, population base, proximity to major highways and other variables beyond local control.

RECOMMENDATION 33 **THAT lottery funds be used for one-time, start-up grants for capital upgrading, to be provided on application to the Commission for assistance in the establishment of Basic Life Support service.**

RATIONALE: Albertans and community groups continue to show interest in the use of lottery monies in support of health care. The upgrading of ambulance services to Basic Life Support, where not financially possible for a given municipality, would certainly be considered a laudable use for lottery funds. A capital grant would create the necessary impetus for all ambulance operations to embrace Basic Life Support, while also providing recognition of the province's establishment of Basic Life Support as a universal minimum. Ambulance services already operating at a Basic Life Support level are to be commended, but could not be reimbursed for their development costs.

RECOMMENDATION 34 **THAT the province bear the cost of establishing and operating the central ambulance communications system.**

RATIONALE: Provincial funding for both the capital and operational expenditures for communications would ensure establishment of a standardized, effective system, capable of addressing present and future needs. Such a communications centre would be a one-time capital expenditure which would benefit all Albertans.

RECOMMENDATION 35 **THAT the Emergency Health Services Commission be asked to develop a funding system for medical transportation to ensure that the most cost-effective, medically appropriate mode of transportation is used.**

RATIONALE: Given the complexities of the present funding system, a complete analysis would be important.

Adjustments to interhospital transfer funding would be necessary in order to cover the costs of transferring outpatients as required for appropriate medical treatment.

Further, the emergency air ambulance program has, since its inception, been totally funded by the provincial government. Co-ordination of all modes of emergency transportation, with equitable funding applied throughout, is required to provide Albertans with equal access to their health care system.

Interhospital and Interprovincial Transfers

RECOMMENDATION 36

THAT interhospital transfers, appropriate to the medical condition of the patient, be scheduled through central dispatch.

RATIONALE:

Co-ordinating transfers through the use of central dispatch would enable the ambulance system to make optimal use of vehicles and personnel resources, and reduce instances of air and ground ambulances travelling empty on return trips to base stations. The co-ordinating function of central dispatch could be extended to audit, and subsequently reduce, the occurrences of inappropriate use of ambulances. It is expected that the central dispatch function would result in significant savings in the cost of delivering ambulance services.

RECOMMENDATION 37

THAT commercial transportation be used, where medically appropriate, for interhospital transfers.

RATIONALE:

Medically required transportation does not always necessitate the use of a dedicated charter aircraft or ground ambulance, and the recommendation to send patients on regularly scheduled airlines, buses or taxis, as appropriate, supports the use of transportation suitable to individual medical needs.

Certainly the use of only charter aircraft for air ambulance transport and interhospital transfers overlooks the potential cost savings of using commercial air transport where medically appropriate. In instances where medical personnel are required to accompany a patient, their travel costs would also be covered.

RECOMMENDATION 38

THAT outpatients no longer be charged, beyond an initial co-insurance fee, for ambulance service deemed medically required for transfer.

RATIONALE:

In the present system, inter-hospital transfer of in-patients is paid for by the hospital which admitted them. Outpatients, however, are responsible for their own costs. Incorporating outpatient transfers into the funding structure for ambulance services would rectify this inequity and also recognize the ambulance as a vital entry point to the health care system.

RECOMMENDATION 39

THAT guidelines for interprovincial ambulance service be set through the Commission.

RATIONALE:

The co-ordination of interprovincial transfer of patients requires the establishment of service guidelines. The Emergency Health Services Commission would be the most appropriate administrative body to develop these guidelines.

Air Ambulance

RECOMMENDATION 40

THAT strict guidelines, set by the Commission, be applied to the use of fixed and rotary wing aircraft.

RATIONALE:

Each type of aircraft can be of value to the air ambulance service. However, to maximize these resources and manage costs, guidelines are required to identify appropriate use of each aircraft. Requirements for adherence to these guidelines would assist the provincial agency in preventing inappropriate or excessive use of specific types of aircraft, and thereby increase the cost-effectiveness of the air ambulance service.

RECOMMENDATION 41 **THAT a registry of qualified aircraft operators be maintained.**

RATIONALE: The use of a registry, listing qualified air carriers from the private sector, would continue the involvement of the private sector while increasing flexibility in the deployment of resources.

NOTE: Other recommendations directly affecting air ambulance include Recommendations 1, 2, 3, 4, 9, 11, 17, 26, 27, 31, 35, 36, 37, 38, 39.

PROVINCIAL AMBULANCE SYSTEMS

THE PRESENT ALBERTA AMBULANCE SYSTEM

This section of the report describes the ambulance system as it exists in Alberta. A comparative analysis between and among the ambulance systems of British Columbia, Alberta, Saskatchewan, Manitoba and Ontario follows.

The description of Alberta's system, and comparisons with the other provinces, focus on addressing issues, concerns and needs, with respect to legislation, organizational structure, funding of service, mechanisms for reporting activity, training programs, standards, communications, and volunteers.

Legislation

Ambulance service in Alberta is currently regulated by several pieces of legislation, none of which is directly responsible for ambulance activity.

The Municipal Government Act authorizes any municipality to develop and implement by-laws regulating ambulance activity, but does not dictate the establishment of ambulance service. Accordingly, municipalities are free to choose the type and level of ambulance service provided in their communities.

Minimum standards for ambulance vehicles were regulated under the Motor Vehicle Transport Act until February 15, 1987, at which time the Act was rescinded and these standards eliminated. However, the Motor Transport Act prescribes standards and conditions for running and operating of public vehicles. Regulations controlling the use of sirens, flashing lights, and other pertinent traffic-related matters are contained within the Highway Traffic Act. Controls provided by this legislation are largely limited, however, to those affecting the movement and emergency fixtures of ambulance vehicles.

The legislation which governs ambulance activity to the greatest degree is the Health Disciplines Act, which controls the medical procedures and educational criteria of all registered Emergency Medical Technicians. However, this falls short in that it applies only to individuals who are registered and licensed as Emergency Medical Technicians-Ambulance and Emergency Medical Technicians-Paramedics; anyone not so registered or licensed is not governed by legislation while performing ambulance service duty.

To complete the list of legislation affecting ambulance activity, the Labour Standards Act identifies labour-related requirements in this field.

Existing legislation regulating ambulance activity in Alberta fails to address significant elements of service delivery. These include vehicle and equipment standards, educational criteria for all ambulance attendants, monitoring and evaluation methods for service delivery, information reporting, and communications systems.

Organizational Structure

The Alberta government has not been involved in developing specific organizational structures for optimal delivery of ground ambulance service. Currently, this service is provided by municipalities, by volunteer organizations, by private businesses or, when municipalities delegate their responsibility, by hospitals or private operators.

Of the ground ambulance services operating in Alberta, 103 belong to a nonprofit organization — the Alberta Ambulance Operators Association (AAOA). This association lends support in areas of common interest, such as the development of equipment and vehicle standards, provision of an inspection service, and negotiation of fee schedules for member agencies. Officials of the association are members elected to serve specified terms in office. Each member agency has its own particular organizational structure. Currently, the number of ambulance services operating as non-members of this voluntary organization is small.

Many ambulance services in Alberta report to a governing body, which may be a municipal council, a hospital board, an ambulance board/authority, or a volunteer group. Members of these governing bodies in turn may be elected or appointed, or be volunteers.

Conversely, air ambulance is a provincially funded service, with a hierarchical structure used to administer the funding and budgeting of air ambulance costs. This organizational structure within the Department of Hospitals and Medical Care presently employs staff responsible for air ambulance activity (see Appendix 3, Figure 1.

Reporting Systems

The reporting of ground ambulance activity and the development of reporting systems in Alberta are independent of the provincial government. The provincial agency responsible for air ambulance service has established a reporting system for the sole purpose of recording all services delivered in support of air ambulance. This system uses standardized forms for recording patient information, and is fully automated.

Ground ambulance service not associated with emergency air ambulance service is not reported to the province. Ground ambulance operations are individually responsible for record-keeping, and at present no standardized patient-care reporting system has been developed to provide activity information to a central information system. Ground ambulance services are not required by regulation or law to submit activity records to any of the provincial departments that either directly or indirectly fund these services.

Funding for Ambulance Services and User Costs

The funding structure for ambulance services in Alberta is a complex series of provincial grants and municipal contributions. Three separate provincial departments are involved in providing monies, as are many municipal governments.

Alberta Hospitals and Medical Care funds air ambulance services and related ground ambulance activity, and provides related funding to the Alberta Blue Cross insurance plan. The Department also provides global funding to hospitals throughout the province, with monies included for the transfer of inpatients between hospitals. Alberta Social Services covers ground ambulance service costs according to social assistance regulations, and Alberta Municipal Affairs provides municipalities with unconditional grants that can be applied to the operational and capital costs of ambulance services. In addition, some municipal governments have assisted in enabling services to equip at an advanced life-support level.

User costs for ambulance services vary, as only 25 per cent of Albertans are covered by the Alberta Blue Cross insurance plan. This plan pays all associated ground ambulance costs. Users who are not insured, however, must make payment themselves. The costs incurred for Basic Life Support service are $101.00, plus $1.56 per kilometre travelled by the patient.

Funding for Ambulance Service

The 1986/87 fiscal year expenditure by provincial government departments on ambulance services was $36 million.

Of these expenditures, $5.6 million were for air ambulance and $30 million for ground ambulance. Alberta Municipal Affairs collects data on monies provided to municipalities, but not specific information clearly indicating the extent of municipal support to ground ambulance services. Further, no records are kept of the amount of support in the form of assets provided to ambulance services by volunteer groups.

Training of Ambulance Personnel

In Alberta, three post-secondary institutions provide programs, accredited by the Royal College of Physicians and Surgeons, for the training of ambulance personnel: the Southern Alberta Institute of Technology (SAIT) in Calgary, the Northern Alberta Institute of Technology (NAIT) in Edmonton, and the Alberta Vocational Centre (AVC) in Lac La Biche. In addition to the training available at these institutions, St. John's Ambulance provides courses in basic first aid and in cardio-pulmonary resuscitation.

The ambulance training programs prepare students for careers as Emergency Medical Technicians — Ambulance (EMT-A) and/or as Emergency Medical Technicians — Paramedic (EMT-P). Although AVC provides course requirements for the EMT-A only, SAIT and NAIT offer advanced training for the EMT-P as well.

Personnel with the EMT-A designation have been trained in physiology, emergency crisis intervention, intravenous therapy and the application of anti-shock garments. EMT-Ps complete additional training in cardiac care, emergency crisis intervention, intravenous therapy and pharmacology.

The levels of ambulance personnel operating in the province can be described as EMT-A, EMT-P and ERU. The ERU, or emergency response unit (member), is trained to the St. John's Ambulance basic first aid level and functions primarily as a volunteer in rural areas of low population.

Training is either provided by the ambulance service employer or initiated by ambulance attendants themselves.

Present outreach programs of educational upgrading and skill maintenance for ambulance personnel are inadequate in terms of consistency of curricula and availability in rural areas. NAIT and SAIT are developing continuing education programs for EMT-As and EMT-Ps, but no such program is planned for persons at the Emergency Response Unit (ERU) level.

Ambulance Personnel and Equipment Standards

Alberta does not have regulations and standards applicable to all aspects of ambulance service, whether ground or air. Before February 15, 1987, minimal standards for ambulance vehicles and some of the equipment were provided in the Motor Vehicle Transport Act.

The Health Disciplines Act specifies minimum standards for the conduct of EMT-As and EMT-Ps, but does not have jurisdiction over ambulance personnel who are not registered or licensed in these professional categories.

Communications System

Ambulance operations throughout the province use a variety of methods for communicating. Urban service operators have generally responded to communications needs with sophisticated radio and mapping technology for control through a centrally located dispatch. In rural and less populated communities, use of advanced radio communications is limited. Instead, rural ambulance operators employ basic paging systems to alert personnel when service is needed.

A communications system has not been developed to co-ordinate emergency air ambulance service. Aircraft used in this role, however, are generally equipped with appropriate radio communications, although air-to-ground telephone linkages are not standard equipment.

Responsibility for an ambulance communications system rests with the individual operator.

Present ambulance communications systems in Alberta cannot be linked to form a province-wide system. Inter-linking various agencies or components of emergency services is not possible, given that a central dispatch and a universal 911 number have not been developed.

Calling for ambulance service proves difficult where telephone access is specific to the local area and also dependent on local telephone systems and operators. A 911 number for emergency access provides a direct telephone link to the nearest emergency dispatch operator, and overcomes the deficiencies of local telephone operator systems.

Volunteers

The use of volunteers in delivering ambulance service is most pronounced in rural Alberta. Here, the volunteer acts in the role of ERU and often provides the first support to ill or injured persons. Volunteers are of great assistance to the existing Alberta ambulance service, as many small communities do not have the call-volume or the willingness to employ EMT-As or EMT-Ps.

Purchasing

A system for purchasing equipment, supplies and vehicles for ambulance services has not been developed in Alberta, though affiliation with local hospitals presently allows some services to participate in joint purchasing of equipment and supplies, and additionally to gain through a federal sales tax exemption for hospital supplies.

Comparison of Provincial Ambulance Systems

Overview

Ambulance systems in British Columbia, Saskatchewan, Manitoba and Ontario have recently been reviewed internally and are in the process of improvement. British Columbia operates a provincially controlled system and plans to upgrade communications, inspection and evaluation activities in the near future. Saskatchewan has progressed in the implementation of many of the recommendations from the 1983 Birkbeck Ambulance Report. Manitoba has prepared legislation that would consolidate all regulations concerning ambulance service, and Ontario, with its provincially funded system, is currently refining existing regional communications.

This section of the report briefly describes the operation of each provincial system, then compares these systems on the basis of a predetermined set of criteria. These criteria include legislation, organizational structure, reporting systems, funding structure and costs, communications, training and personnel qualifications, standards, and types of services provided.

The Committee's investigation into these neighboring ambulance services revealed a number of common themes. The provinces of British Columbia, Saskatchewan, Manitoba, and Ontario have emphasized the need to provide governing legislation that appropriately describes the mandate of the ambulance service. They continue to review and update the development and setting of standards on matters such as vehicles, equipment, and provision of a minimum level of service. In addition, these provinces have applied communications technology to advance their ambulance communications systems, which control both ground and air ambulance for emergency and interhospital transfer services and which, for the most part, are centralized on a regional or province-wide basis.

While the respective provincial authorities have directed much activity toward progressive development in areas of legislation, standards and communications, they still recognize the role of volunteerism and the uniqueness of local circumstances. Efforts to improve ambulance services have maintained a certain flexibility and have considered the requirements of volunteers or local communities.

The developments and commitments in these four provincial jurisdictions demonstrate that ambulance services are accepted as an integral component of the health care system.

British Columbia

British Columbia's present ambulance system was established in 1974 with an equivalency of Basic Life Support as the minimum level of service. The system and its administrative Commission are controlled by specific legislation. The Commission's responsibility for all air and ground ambulance service operations in the province includes every aspect of delivery and administration of service, from the training of personnel to the establishment of new service locations. No private ownership of ambulance operations exists in this province.

British Columbia employs a three-tiered system for distinguishing among the qualification categories of ambulance personnel, classified as Emergency Medical Assistants (EMA), levels I, II, or III. All personnel are trained at the British Columbia Justice Institute.

Air and ground services function on both an emergency and a transfer basis. Communications for air ambulance operate from a centralized dispatch centre in Victoria and provide scheduled flights able to carry multiple transfer patients to and from tertiary facilities. Ground service communications operate from three regional dispatch centres and utilize a radio broadcast system with specifically assigned frequencies. The province's communications system can interconnect with the telephone system and is able to access the RCMP radio system as back-up. A province-wide reporting system has been implemented, using standardized forms and procedures. Resulting information serves to provide patient reports that stay with the patients, and an ambulance management information system. The reporting system also maintains current information on the provincial bed registry. Additionally, the British Columbia ambulance system has developed and implemented province-wide protocols for patient care.

User fees in British Columbia are applied to ground and air ambulance services alike. Costs are controlled through a central provincial purchasing and dispensing unit that replaces, among other items, supplies and equipment for the ambulance services. The unit is also responsible for the assembly of ambulance vehicles, thereby ensuring standardization of vehicle and equipment configurations. Annual operating costs for the British Columbia system total $55 million.

Saskatchewan

An extensive evaluation of the ambulance system in Saskatchewan in the early 1980s culminated in the 1983 Birkbeck report. Many of the recommendations of this report have been implemented.

The Ambulance Act, scheduled for proclamation in the Spring of 1988, effects controls on the delivery of ambulance services in the province. Supporting legislation, which consolidates all previous laws, is included in the Public Health Act which now ensures the enforcement of standards for personnel, vehicles and equipment. The Saskatchewan ambulance system is composed of the Ambulance Services Unit, which is a government agency, and independent ambulance boards with designated boundaries (see Figure 4, Appendix 3). Ambulance boards are empowered to act directly as management bodies controlling ambulance services, or to act as the province's funding agency. Ambulance operators are required to meet prescribed standards and are licensed annually.

Qualifications for Saskatchewan's ambulance personnel range from a First Responder category (entailing a first aid certificate and cardio-pulmonary resuscitation qualifications) through an Emergency Medical Technician (EMT) level to Advanced Emergency Medical Technician (AEMT). This training is arranged through the Wascana Institute under curriculum direction from the government.

Emergency air ambulance services are provided by the Property Management Corporation under contract to Saskatchewan Health. The Ambulance Service Unit serves as the monitoring agency responsible for the maintenance of training and service standards, and provides administrative support for the funding of the province's 104 operating ambulance services.

Communications and dispatch centres are currently the responsibility of local services; however, a provincial system is being developed to utilize specific radio broadcast frequencies and telephone access through a 911 number. Although a reporting system is not yet operational, standardized reporting procedures have been implemented using common forms, operational and procedural manuals, and treatment protocols.

Users of ambulance services in Saskatchewan are assessed basic charges, set by individual districts, which combine a specified base rate and a kilometre charge. However, as a result of benefits provided under private and government insurance plans and provincial and federal government programs, only 25 per cent of users are billed. The Saskatchewan Government in 1986/87 expended $9.2 million in direct and indirect subsidies for ambulance services.

Manitoba

In Manitoba, ambulance services were reviewed in 1986. This review incorporated a thorough restructuring of government groups involved with ambulance services under the Emergency Health and Ambulance Services Division (see Figure 5, Appendix 3). As well, new legislation has been tabled which will establish government control over many aspects of ambulance service in the province.

The training of Manitoba's ambulance personnel ranges from a basic first aid level (16 hours) through Emergency Medical Attendant courses (128 hours) for ground ambulance services only, to critical-care nursing preparation for aeromedical conditions.

Air ambulance services, staffed by specially-trained critical-care nurses, are provided by the province's Emergency Health and Ambulance Services Division on an emergency-only basis. Ground ambulance services are locally operated and funded by the municipality. The province maintains a staff of ambulance officers who monitor all ambulance service activity and have the power of licensing these services.

Communications and dispatch for ground ambulance are local responsibilities. The province has implemented a standardized reporting system that provides patient and ambulance information to the ambulance service, the hospital and the provincial agency.

The Manitoba ambulance system operates with strong support from individual volunteers, volunteer groups and service clubs. Historically, in non-urban areas, volunteers have provided manpower and donations of equipment amounting to a system of private citizen funding for ambulance services.

Manitoba users are responsible for ground ambulance charges whether or not they are in support of air ambulance. The province financially supports ambulance services through per capita grants to municipalities for ground ambulance services ($2.25/capita — average), a specific northern emergency air ambulance (north of the 55th parallel) transportation grant program, and special funds for air ambulance services. The 1986/87 expenditure by Manitoba's government for ambulance services was $7 million.

Costs for providing ground ambulance services in Manitoba, however, are difficult to estimate, since these services are funded by local municipalities with

extensive, unrecorded volunteer support and assistance. Air ambulance activity is concentrated in areas north of the 55th parallel, and subsequently serves a minority of the province's population.

Ontario

Ambulance services in Ontario have evolved, from a foundation set down in the Ambulance Act of 1966, into a comprehensive and complete system. The Emergency Health Services Division of the Ministry of Health is the controlling government body authorized to license, set standards, and co-ordinate ambulance services and an associated communications system (see Figure 6, Appendix 3). The ambulance legislation in this province was amended in 1975 to expand the requirements for ambulance service delivery.

Personnel training standards in Ontario require a minimum level of service to be available in all patient-care situations. The basic educational criterion is a one-year community college program followed by successful completion of a Ministry-administered certification process to the Basic Life Support level, to become an Emergency Medical Care Attendant (EMCA). An advanced life support or paramedic program is also available, but Ontario has not totally embraced the need for paramedic care. The underlying philosophy in this province is to provide medical practitioners when required, rather than to create an intermediary level of medical care in the form of paramedic service. Since 1975, everyone entering the ambulance services field has been required to possess a valid EMCA standing.

In Ontario, air and ground ambulance services are operated on both an emergency and a transfer basis. The majority of air ambulance activity occurs in the more northern parts of the province.

Communications and dispatch centres are operated directly by the provincial agency and are under review for expansion purposes. Central Ambulance Communications Centres (CACC), regionally and centrally located, handle all ambulance dispatch needs. Ontario established an advanced communications system in conjunction with a province-wide information-reporting system. The latter, which is to be upgraded, combines both dispatch information and ambulance/patient information.

Users of ambulance services in Ontario now pay a $22.00 fee for other than interhospital transfers, which are exempt (and represent one-third of all trips). The application of this user fee is currently under scrutiny, as only 50 per cent of fees collected are returned to the government, with the other 50 per cent used by hospitals as discretionary income. The province fully funds all ambulance services except for those in Metropolitan Toronto, which receives funding for 75 per cent of its approved expenditures. Total annual provincial expenditures for ambulance services in Ontario amount to $167.5 million.

Analysis of Provincial Systems

A brief review of the similarities and differences among these provincial systems follows, and again the analysis is based on the criteria of legislation, organizational structure, reporting systems, funding structure and costs, communications, training and personnel qualifications, standards, and types of services provided. The table at the end of this chapter, "A Comparison of Ambulance/Emergency Medical Services Systems," has been included for quick reference.

Legislation

Legislation has been introduced to monitor, regulate and develop ambulance services in four of the five provinces examined. **Alberta** alone has not taken legislative steps to ensure the regulation of ambulance services.

The legislative situations across these five provinces vary. In four provinces, the trend is to combine all legislation related to ambulance services under single Acts.

With the exception of **Alberta**, current legislation in these provinces is consistent in requiring:

- standards of service that are set and monitored by government,
- adherence to a province-wide reporting system, and
- co-ordination of ambulance services through a centralized communications system.

Governments in **British Columbia, Saskatchewan, Manitoba** and **Ontario** have set up administrative bodies responsible for ambulance services. This legislative commitment ensures a minimum level of service for all citizens.

Organizational Structure

Each province has established an organizational structure appropriate to its respective ambulance

service (see Figures 1-6, Appendix 3). The structures change as volumes of activity increase and new areas of responsibility are added.

Organizational structures in four of the five provinces regulate the activities of independent ambulance operators, of government-sponsored operators and of ambulance services directly operated by government. Only the Alberta organization does not unite ground and air ambulance administrative jurisdictions and is not able to regulate ground ambulance services. The other four provinces, because of their combined air/ground services administration, are likely able to change their systems as economics and environmental need demand. The same cannot be said of the organizational structures in Alberta.

Funding for Ambulance Services, and User Costs

When health care insurance systems were first established, ambulance services were not considered. Revenues came from direct charges for ambulance service, with costs of service paid by the users or their private insurance plans. Funding of ambulance services in all five provinces relies heavily on provincial government budgets. Local needs are reflected in the manner in which financial resources are distributed. **British Columbia** operates its own ambulance services and does not redistribute funding in any way. In **Alberta**, financial resources for ambulance services are distributed to municipalities, hospitals and the insurance plan through three separate agencies. **Saskatchewan** allocates funding, based on municipal grant arrangements, directly to local ambulance boards. Municipalities in **Manitoba** receive grants from the province for ambulance operations, and **Ontario** provides full funding for ambulance activity, except in Toronto.

User fees in the five provinces vary with the level of insurance coverage: the more coverage, the less cost to the user. Insurance plans, whether private or provincial, either cover from 80 to 100 per cent of costs, or establish a maximum allowable payment. British Columbia has established a basic rate and a kilometre charge, as have Saskatchewan and Manitoba. Users of ambulance services in Ontario are not assessed kilometre charges, and a basic rate is not applied in Alberta.

Reporting Systems

The monitoring of ambulance service delivery relies on accurate records of activity. These records are required by the ambulance operator and the funding agency to determine appropriate collection and distribution of funds for services rendered. The reporting systems used in the five provinces studied vary considerably in monitoring capability and general procedures.

In general, provincial reporting systems collect patient information that remains with the patient to assist in diagnosis and choice of treatment modalities, and can later be used for medical audit and accounting purposes. Only **Alberta** has not subscribed fully to such a mechanism for information collection. **British Columbia, Saskatchewan, Manitoba** and **Ontario** all use standardized reporting forms and instruction manuals to ensure the integrity of their reporting systems. Legislation and regulations in these four provinces require the reporting of all ambulance activity.

Training Requirements

Training requirements for ambulance personnel depend largely on the given philosophy of the province in which the individual is employed. Prior to the establishment of specific ambulance legislation in any of the provinces, ambulance service was basically a "scoop-and-run" process, and was not controlled by any consistent medical criteria. With the introduction of legislation and organizational change in the provinces' emergency services, ambulance activity became more of a medical service, particularly with respect to training and qualifications required of personnel operating ambulances and providing care to patients. Training requirements in these five provinces vary considerably. The EMA I qualification in **British Columbia** and EMCA in **Ontario** establish Basic Life Support as the minimum level of training for ambulance personnel. A much lower minimum level in **Alberta, Saskatchewan** and **Manitoba** is based on ERU, first responder and first aider qualifications. The impact of these minimum requirements is primarily felt in rural communities, as operators in urban areas have greater economic resources and subsequently can employ more qualified ambulance personnel.

The training background of entry-level personnel educated at technical colleges is similar from province to province. Skills are learned and developed in cardiac and respiratory care, emergency crisis intervention,

and patient and equipment handling. The skills incorporated in more advanced training programs vary with the service needs of each province. In **British Columbia**, various levels of EMA IIIs deal with specific patient conditions, whereas in **Alberta** the EMT-P is prepared to effectively handle all potential needs. AEMTs of **Saskatchewan** are restricted to a non-paramedic level of care. Paramedics in **Ontario** are limited in number but are trained to standards as high as those of the EMA III in **British Columbia** and the EMT-P in **Alberta**. **Manitoba** has not entered the field of the advanced emergency paramedic.

Transportation Modes

Each of the five provinces must contend with the geographical distances between centres of population serviced by trauma and emergency facilities. Northern populations are often isolated because economic considerations have prevented the establishment of transportation systems in these more remote areas. Ambulance services are faced with adapting to such conditions.

Although the five provinces are consistent throughout in terms of emergency and transfer ground ambulance services, each provincial jurisdiction takes a slightly different approach to air ambulance service. **British Columbia** and **Ontario** use air ambulance for emergency and transfer purposes. **British Columbia, Saskatchewan** and **Manitoba** all directly employ dedicated aircraft as air ambulances, while **Alberta** and **Ontario** obtain such services either through fees-for-service or through contractual arrangements. Rotary wing aircraft are used in **British Columbia, Alberta** and **Ontario**, but are not planned for in **Saskatchewan** and **Manitoba**.

Application of Standards

Ambulance systems in the five provinces have applied varying degrees of standardization for protocols, vehicles and equipment.

Four provinces, excluding **Alberta**, have legislated minimum standards for vehicles and equipment. These standards eliminate the need for re-training as equipment varies from system to system, while reducing the risk of damage to equipment through misuse or misapplication.

Alberta is the only province among those studied that has not implemented the mechanisms enabling development of appropriate ambulance service standards. The Provinces of **British Columbia** and **Ontario** have developed comprehensive standards to ensure a high quality of ambulance service to their citizens. **Manitoba** and **Saskatchewan** are in the process of developing standards.

Communications

Today's technology offers the potential for almost instantaneous communication (information exchange) through a variety of systems, such as satellite, cellular telephone, radio broadcast, and air-to-ground radio-telephone links.

The communications system is an integral component of ambulance service, ensuring optimum response time in emergencies. Each ambulance operator, whether working within a provincial communications network or an independent service, relies on communications links for accurate information and service delivery.

Sophisticated technology for ambulance communications is currently in use in **British Columbia** and **Ontario**. **Alberta** does not have a unified, compatible or interconnected system. Communications in this province are the responsibility of individual ambulance operators and accordingly cannot match the efficiencies in service delivery in **British Columbia** and **Ontario**. **Saskatchewan** has initiated planning and development of a province-wide communications system to overcome deficiencies identified by the 1983 Birkbeck report. **Manitoba** operates an air ambulance communications system, but has yet to address its ground ambulance communications needs.

Volunteers

Although many citizens would prefer that ambulance services were staffed by full-time, highly trained attendants, staffing at this level is not always feasible. In rural Canada, the volume of activity of ambulance service does not warrant a fully-staffed organization. Particular solutions applied to this problem vary in the five provinces; in general, however, the emphasis is on using trained volunteers.

Volunteers represent a vital staffing component of rural ambulance services in **Alberta, Saskatchewan, Manitoba** and **Ontario**. The extent of provincial support to the volunteer, however, can vary within the province as well as between provinces.

Comparison of Ambulance/Emergency Medical Services Systems
Five Provinces (1986/87)

CRITERIA OF COMPARISON	BRITISH COLUMBIA	ALBERTA	SASKATCHEWAN	MANITOBA	ONTARIO
Legislation	- Comprehensive single act	- Five acts - Limited regulations	- Two acts providing comprehensive coverage	- Two acts - Comprehensive act tabled	- Two acts providing comprehensive coverage
Organizational Structure	SEE ATTACHED CHART - Page 76	SEE ATTACHED CHART - Page 74	SEE ATTACHED CHART - Page 77	SEE ATTACHED CHART - Page 78	SEE ATTACHED CHART - Page 79
Operational Funding Responsibilities	- Prov. Gov't. air and ground	- Prov. Gov't. air - ground 100% shared by municipality and user except for special subsidies	- Prov. Gov't. air and ground	- Prov. Gov't. air (including the Northern Transportation Grant Program) - Ground 100% shared by municipality and user	- Prov. Gov't. air - Prov. Gov't. ground except 75% funding to Toronto Department of Ambulance Service
Capital Funding Responsibilities	- Prov. Gov't.	- Prov. and Municipal, Gov't. operator and volunteer contribution	- Prov.and Municipal Gov't. and volunteer contribution	- Prov. and Municipal Gov't. and volunteer contribution	- Prov. and Municipal Gov't and volunteer contribution
Co-insurance Charges	- Basic fee of $28 plus $1.28 per km to maximum of $180	- None established	- Basic fee of $60 plus $.50 per km	- None established	- Basic fee of $22; no km charge
User Costs	- None other than co-insurance charges	- Ranges from $0 to $131 plus $1.56 per km	- None other than co-insurance charges	- Ranges from $0 to $56 plus $1.18 per km	- None other than co-insurance charges

CRITERIA OF COMPARISON	BRITISH COLUMBIA	ALBERTA	SASKATCHEWAN	MANITOBA	ONTARIO
Reporting Systems	- Standardized air and ground	- Standardized air - Non-existent ground	- Standardized air and ground	- Standardized air and ground	- Standardized air and ground
Training Requirements	- Post-secondary training for Emergency Medical Assistant (EMA) - Government regulated - Minimum level EMA-I - Three levels of EMA (I,II,III)	- Post-secondary training for Emergency Medical Technician (EMT) - Minimum level first aid and CPR - Minimum level is Emergency Response Unit (ERU) - Two levels of EMT (EMT-A & EMT-P)	- Post-secondary training for Emergency Medical Technician (EMT) - Minimum level first aid and CPR - Minimum level is First Responder - Two levels of EMT (EMT & AEMT)	- Government training as a First Responder - Government regulated - Minimum level first aider - Critical care nurses staff air ambulance	- Post-secondary training as an Emergency Medical Care Attendant (EMCA) - Minimum level EMCA - Two levels of EMCA (EMCA and paramedic)
Qualification Equivalencies to Alberta's EMT	- EMA II equates with EMT-A - EMA III equates with EMT-P		- EMT lower than EMT-A - AEMT between EMT-A & EMT-P	- First Responder lower than EMT-A	- EMCA equates with EMT-A - Paramedic equates with EMT-P
Transportation Modes Available	- Air (provincial standards) - Fixed wing - Rotary wing - Ground (provincial standards)	- Air (no provincial standards) - Fixed wing - Rotary wing - Ground (no provincial standards)	- Air (no provincial standards) - Fixed wing - Ground (provincial standards	- Air (provincial standards) - Fixed wing dedicated - Ground (no provincial standards)	- Air (provincial standards) - Fixed wing - Rotary wing - Ground (provincial standards)

CRITERIA OF COMPARISON	BRITISH COLUMBIA	ALBERTA	SASKATCHEWAN	MANITOBA	ONTARIO
Training Standards	- Developed by provincial government - Compulsory - BLS minimum	- Developed by volunteer assoc. - Noncompulsory - ERU minimum	- Developed by provincial government - Compulsory - BLS minimum	- Developed by provincial government - Compulsory - First Responder minimum	- Developed by provincial government - Compulsory - BLS minimum
Communications	- Extensive broadcast system - Province-wide - Central dispatch (air) - Regional dispatch (ground, three locations) - Air-to-ground and radio-telephone equipped - Future developments - 911	- Independent, based on operators needs - Ground dispatchers in major urban centres - Consideration of 911 initiated	- Province-wide system being developed - Central dispatch (air) - Regional dispatch (ground) - Radio-telephone system under consideration - 911 planned	- Independent, based on operators' needs	- Province-wide system in place - Air-to-ground, ground-to-ground, radio-telephone and FAX equipped - Central dispatch (air) - Regional dispatch (ground, 18 locations)
Volunteers	Volunteers are used to varying degrees in all provinces and are generally trained to first aid and C.P.R.				

APPENDICES

GLOSSARY

Accredited (Accreditation)
The process by which the Royal College of Physicians and Surgeons recognizes the credibility of an educational program that meets the College's established criteria of performance.

Advanced Cardiac Life Support (ACLS)
A skill level attainable by physicians and Registered Nurses that prepares them to operate effectively in a non-clinical emergency setting with respect to cardiac trauma.

Advanced Emergency Medical Technician (AEMT)
The advanced level of Emergency Medical Technician available in Saskatchewan. This skill level is equated to a mid-range skill level between the Emergency Medical Technician — Ambulance and the Emergency Medical Technician — Paramedic of Alberta.

Advanced Life Support (ALS)
The most sophisticated level of ambulance service provided in Canada. Services provided by ALS personnel include, among other techniques, advanced cardiac care (ie. defibrillation), administration of pharmacological agents used to stabilize critically ill or injured persons, and nasotracheal intubation. Emergency Medical Technicians — Paramedic in Alberta are trained to operate in the ALS environment under the guidance of a medical director.

Aeromedical Condition
The physiological effects that could be experienced by a patient as a result of from transport in the airborne environment, influenced by such factors as whether or not the cabin is pressurized.

Air Ambulance
The use of a specially-outfitted aircraft as the transportation mechanism for moving or transferring patients to or between hospitals.

Alberta Ambulance Operators Association
An association that acts as a collective voice, on behalf of member ambulance operators, in presenting and dealing with issues of concern to the membership. Membership in the Association is voluntary.

Alberta Urban Municipalities Association
An association that acts as a collective voice, on behalf of cities, towns and villages, in presenting issues and concerns of interest to its membership to the provincial government. Membership in the Association is voluntary but dependent upon the criteria that defines a city, town or village in Alberta.

Alberta Vocational Centre
An educational institution located at Lac La Biche that offers an accredited program for the Emergency Medical Technician — Ambulance.

Ambulance
Any publicly or privately owned vehicle that is especially designed, constructed, modified and equipped, and used for the transportation of persons who are sick, injured, wounded or otherwise incapacitated or helpless.

Basic Life Support (BLS)
Basic Life Support (BLS) is an ambulance service which provides personnel qualified to the Emergency Medical Technician — Ambulance level and registered by the Health Disciplines Board, along with the necessary equipment and communications network to support the role. The term also refers to personnel qualifications for this level of service.

Bed Registry
A current and centralized status report of available beds and staff, and the capability to provide appropriate patient treatment, in a specified group of hospitals.

Cardio-Pulmonary Resuscitation (CPR)
A medical technique using external compression of the chest to stimulate heart muscle contraction in conjunction with oxygen ventilation of the lungs for maintaining the flow of oxygenated blood in the human body.

Co-Insurance Charge
Minimum charges that outpatients transported by ambulance are responsible for, that are additional to the patient's provincial health insurance coverage.

Consumer
The individual, or an institution such as a hospital or nursing home, utilizing ambulance services in Alberta.

Dispatcher
A person who operates radio and telephone equipment for the purpose of receiving calls for ambulance service and dispatching ambulances.

Dispatch Centre
A communications centre that is equipped to receive calls for ambulance service and to dispatch air and ground ambulances by radio or telephone, and that is used for such purposes.

Emergency Medical Technician Ambulance (EMT-A)
An ambulance attendant trained to provide Basic Life Support services under the guidance of a medical director, in the attendance and transportation of critically ill or injured persons to appropriate health care facilities.

Emergency Medical Technician — Paramedic (EMT-P)
An ambulance attendant trained to provide Advanced Life Support services under the guidance of a medical director, in the attendance and transportation of critically ill or injured persons to appropriate health care facilities.

Emergency Response Unit (ERU)
The current minimum level of ambulance service in Alberta. ERU personnel are trained to provide basic first aid service and cardio-pulmonary resuscitation. These personnel are generally non-paid volunteers who operate in rural and remote locations.

First Responders
First Responders are persons trained to the St. John's modular course or its equivalent advanced first aid and CPR courses. These individuals, used in an Emergency Health Services system in the stabilization of patients, would be integrated with a BLS service in remote and isolated areas of the province. The minimum basic level of trained ambulance attendant in Manitoba is First Responder.

Fixed Wing (Aircraft)
Conventional aircraft, propeller or jet driven.

Inter-Hospital Transfer
The movement of patients between hospitals for assessment, diagnosis, or treatment when the required services are not available at the patient's original hospital location. Inter-hospital transfer is an integral component of the Alberta health care system.

Local, Trained Citizens
Community residents trained to provide basic first aid and responsible for accessing appropriate emergency services for support and/or medical evacuation.

Medevac
The air ambulance emergency medical evacuation of a patient.

Medical Advisor
A physician who, in the case of emergency services, sometimes has specialized training in emergency medical techniques and who provides advice and support, on medically related matters, to an individual or organization.

Multi-Tiered
Refers to various divisions or agencies of an emergency health services system including first responders, ambulance service, fire and police departments, hospitals, etc.

Municipality
A city, town, village, municipal district, county, improvement district or Special Area.

Northern Alberta Institute of Technology (NAIT)
A post-secondary educational institution in Edmonton that offers accredited training programs for Emergency Medical Technicians — Ambulance and Paramedic.

Pre-hospital Emergency Care
Those emergency medical services rendered to emergency patients in an out-of-hospital setting, administered for analytic, stabilizing or preventive purposes, preceding and during transportation of such patients to emergency treatment facilities.

Protocol
An established set of procedures used to carry out specific actions. Protocols have been applied in the Emergency Medical Services industry to all operational activity, including personnel activity, medical supervision, inspections of equipment and vehicles, and communications.

Provider
The individual or organization providing ambulance service in Alberta.

Rotary Wing (Aircraft)
Helicopter.

Southern Alberta Institute of Technology (SAIT)
A post-secondary educational institution in Calgary that offers accredited training programs for the Emergency Medical Technicians — Ambulance and Paramedic.

Stakeholder
An organization or individual that has a major interest, direct or indirect, in the delivery of ambulance services.

User Costs
The costs for ambulance transportation incurred by patients who do not have specific ambulance insurance coverage.

Acronyms Used in the Report

AAMD&C	Alberta Association of Municipal Districts & Counties
AAOA	Alberta Ambulance Operators Association
ACCESS	Alberta Educational Communications Corporation
AHA	Alberta Hospital Association
ALS	Advanced Life Support
AMA	Alberta Medical Association
AUMA	Alberta Urban Municipalities Association
AVC	Alberta Vocational Centre
BLS	Basic Life Support
CACC	Central Ambulance Communications Centre (Ontario)
CPR	Cardio-pulmonary resuscitation
EMA	Emergency Medical Attendant
EMCA	Emergency Medical Care Attendant
EMT-A	Emergency Medical Technician — Ambulance
EMT-P	Emergency Medical Technician — Paramedic
ERU	Emergency Response Unit
NAIT	Northern Alberta Institute of Technology
SAIT	Southern Alberta Institute of Technology
VHF	Very high frequency (radio transmission)

METHODOLOGY

1. Process

The Advisory Committee identified its objectives as follows:

a) to acquire an understanding of the current ambulance system in Alberta,
b) to identify issues,
c) to define a goal statement for the ambulance system,
d) to compile criteria for achieving that goal,
e) to develop and assess alternative solutions, and
f) to prepare a set of recommendations for the Minister.

2. Initial Meetings

Early in the review process, the Committee devoted time to becoming informed about the present Alberta ambulance system. A number of government officials met with the Committee. Considerable documentation relevant to the review, including information on utilization and funding, was provided and studied. The Committee learned of the historical development of Alberta's ambulance services, and became conversant with earlier studies carried out in Alberta and elsewhere.

3. Documentation

Literature is available on ambulance systems and on specific features of the services. Cost and rate comparisons, copies of relevant legislation and regulations, policy statements from various organizations and other provinces, previous reports and recommendations, and pertinent news items were among the materials studied. A list of key documents appears in Appendix 5.

4. Meetings

A Committee priority entailed extensive exposure for the review and gathering as much response on issues as possible. It was felt that the general public, providers and consumers of ambulance service, local governments and various organizations involved directly or associated with ambulance services would have valuable contributions to make. Letters and press releases alerted potential contributors to the review process.

4.1 Stakeholders

The Committee met in camera with representatives of 16 organizations and associations. The list can be found on Page 48.

4.2 Public Hearings

Two sub-committees were formed to attend public meetings in the following Alberta centres: Calgary, Coronation, Edmonton, Grande Prairie, High Level, Hinton, Lethbridge, Red Deer, Medicine Hat, and St. Paul.

Sixty-eight oral presentations were made to the Committee, with the majority submitted by ambulance personnel, local operators, local medical care users and local governments. A significant number were also presented by individuals and community organizations. Presentations were followed by an opportunity for general discussion of issues. Pages 47 and 48 lists presentation participants.

5. Survey Questionnaires

One of the challenges faced by the Committee was to obtain up-to-date, detailed data on Alberta's ambulance services at the operational level. To this end, questionnaires were prepared and distributed to 230 providers and consumers of ambulance services. The providers' questionnaire requested information on the level of service available, qualifications of personnel, type of equipment used, communications, utilization, costs and income, protocols, relationships with other agencies, and information service. Of the 167 questionnaires sent to providers, almost 50 per cent were completed and returned. The consumers' questionnaire inquired as to service received, interfacing arrangements of ambulance services and other agencies, budget impact and other matters. Of the 63 questionnaires sent to consumers, 67 per cent were completed and returned.

Both groups were asked to identify issues and problems, and to propose recommendations for improvement. Copies of the questionnaires can be found in this appendix.

6. Written Submissions

The Committee wrote to all municipalities and hospital boards in the province, asking for their input. To ensure that all Albertans had the opportunity of making their views known, written briefs and letters were invited through advertisements in the daily and weekly newspapers. Ninety-one responses were received, as listed on Pages 48 and 49.

7. Field Research

Committee members visited a number of ambulance stations to gain an understanding of hour-to-hour ambulance operations.

Several other provinces were identified by Alberta Hospitals and Medical Care officials and/or in documentation as having recently conducted similar studies or as having noteworthy features of a modern ambulance service.

Committee representatives visited British Columbia, Saskatchewan, Manitoba and Ontario to meet with system officials, to view operations, and to achieve further documentation. The Committee compiled a comparative base for its deliberations through these visits, and from information from other provinces and the United States.

Addendum to Appendix 2

Public Hearings, Stakeholder Meetings, Submissions and Questionnaires

Anyone with an interest in ambulance services was welcome to meet with the Policy Advisory Committee. Participating delegations are listed below. The Committee received 59 written briefs and 32 letters from organizations and individual Albertans. Each presentation was followed by an open discussion with members of delegations and others in attendance.

Public Hearings — Northern Alberta

Grande Prairie — June 1, 1987

- Manning Hospital
- Grande Prairie Air Service
- Grande Prairie Ambulance Authorit

High Level — June 1, 1987

- Town of High Level
- Aeromedical Ambulance
- Town of Grimshaw
- Northwestern Health and Social Services Board

Hinton — June 2, 1987

- Hinton Hospital Board, Medical Staff, and Hinton Ambulance Ltd. (Joint Presentation)
- Grande Cache Ambulance Service

St. Paul — June 3, 1987

- Northern Alberta Development Council
- St. Paul General and Auxiliary Hospital and Nursing Home District #36
- Lloydminster Emergency Care Services
- Bonnyville Municipal Ambulance
- Lloydminster Area Ambulance Board
- Lakeland Ambulance Services Ltd., Alberta North Star Ambulance Service Ltd., Associated Ambulance Services Whitecourt Ltd., Lac La Biche and District Ambulance Services (Joint Presentation)

Edmonton — June 4 and 5, 1987

- Strathcona Fire Department
- Beaver Ambulance Society
- St. John's Ambulance, Sturgeon Area
- Lyle McKellar, Registered Paramedic, Slave Lake
- University of Alberta Hospitals, Dr. S. Hamilton, Director of Intensive Care Unit
- Omnicare Ambulance
- Employee Association of Omnicare Ambulance
- Bill Coghill, Past President of Alberta Association of Ambulance Operators
- Associated Helicopters
- Mrs. Polack, Citizen
- Dome Ambulance
- Village of Wildwood
- Brooker Wheaton Aviation
- Alan Burkin, Citizen
- Southern Air Transport Association
- Town of Whitecourt
- Edmonton Ambulance Employees Association
- Bruce Barry, Citizen
- Greg Kruse, Former Ambulance Operator

Public Hearings — Southern Alberta

Coronation — June 1, 1987

- Provost Ambulance Service
- Flagstaff Ambulance Authority
- Coronation and District Health Care Complex
- Pat Jacobson, Citizen

Red Deer — June 1, 1987

- County of Red Deer
- City of Red Deer
- Pigeon Lake Ambulance Service
- Town of Innisfail
- Elnora Hospital

Calgary — June 2 and 3, 1987

- City of Airdrie
- Irricana, Beiseker, Crossfield (Joint Presentation)
- District #93, Foothills Hospital, Calgary General Hospital and STAR Board (Joint Presentation)
- High River Hospital and Ambulance Service
- Doug Godsmen, Citizen
- Crossfield
- Flite Paramedic Program
- Ambulance Personnel Association of Alberta
- Elmer Jansen, Mayor of Standard
- Bob Smiley, Paramedic

Lethbridge — June 4, 1987

- City of Lethbridge
- Taber and District Health Care Complex
- Sonia Sitz, Citizen
- Lethbridge Regional Hospital
- Town of Claresholm
- Gergely Helicopters Ltd.
- Earl Scott, Former Administrator of Cardston Hospital
- Av West

Medicine Hat — June 5, 1987

- Medicine Hat City Police
- Air Switch Helicopters Ltd.
- Bow Island Health Centre
- City of Calgary, Emergency Medical Services Department
- Medicine Hat Hospital and Ambulance Service
- Brooks Ambulance Service
- Bar XH Air Inc.

Stakeholders Meetings June 22, 23, 24, 1987

- Alberta Ambulance Operators Association
- Alberta Association of Emergency Medical Services Physicians
- Alberta Association of Municipal Districts and Counties
- Alberta Aviation Council
- Alberta Blue Cross
- Alberta Government Telephones
- Alberta Hospital Association
- Alberta Medical Association
- Alberta Urban Municipalities Association
- Alberta Vocational Centre — Lac La Biche
- Health Disciplines Board EMT Committee
- Health Disciplines Board
- Registered Emergency Medical Technicians Association of Alberta
- Royal Canadian Mounted Police
- Southern Alberta Institute of Technology
- St. John's Ambulance
- Transalta Utilities

Written Submissions

- Airdrie, City of
- Ambulance Personnel Association of Alberta, Eric J. Arnestad
- Archer Memorial Community Ambulance Service, Lamont
- Associated Helicopters Co. Ltd.
- Athabasca No. 12, County of
- Banff, Mineral Springs Hospital
- Barrhead No. 11, County of
- Bar XH Air Inc.
- Beaver Ambulance Society
- Bon Accord, Town of
- Bonnyville Municipal Ambulance
- Bow Island Health Centre
- Bow Valley Ambulance Service, Town of Canmore
- Brooker Wheaton Aviation Ltd.
- Calgary Regional Hospitals and STARS Board
- Camrose, City of
- Canational Aeromedical, Edmonton
- Cardston No. 6, M.D. of
- Claresholm General Hospital
- Coronation and District Health Care Complex
- Crowsnest Pass, Municipality of, Coleman
- Devon, Town of
- Edmonton Ambulance Authority Employees Association
- Edmonton, City of
- Edmonton Disaster Services Health Care Advisory Committee and HCAC Standing Committee on Peacetime Emergency Planning
- Elnora General Hospital
- Emergency Medical Services Department, City of Calgary
- Flagstaff No. 29, County of — Ambulance Operating Authority
- Forest, Dean — EMT — High Level
- Fort McMurray Fire Department
- Fort Saskatchewan General Hospital
- Fox Creek, Town of
- Gergely Helicopters Ltd.
- Gleichen-Blackfoot Ambulance Service
- Grande Cache Ambulance Service
- Grande Cache, Town of
- Grande Prairie Ambulance Service
- Grande Prairie No. 1, County of
- Grimshaw/Berwyn and District Ambulance Service
- Health Sciences Association of Alberta, Edmonton
- High Level, Town of

- High River General and Auxiliary Hospital and Nursing Home District No. 11 and High River District Ambulance Association
- Improvement District No. 14, Alberta Municipal Affairs
- Jasper, Seton General Hospital
- Killam, Town of
- Kowalski, Hon. Ken , Minister of Alberta Environment, Minister, Alberta Public Safety Services
- Lac St. Anne No. 28, County of, Sangudo
- Lakeland Ambulance Services Ltd., Lac La Biche Ambulance Services Ltd., Associated Ambulance Services Whitecourt Ltd., and Alberta North Star Ambulance Service Ltd.
- Leduc, City of
- Leduc No. 25, County of
- Leduc and Area Ambulance Board, County of Leduc
- Lethbridge, City of
- Lloydminster Area Municipal Road Ambulance Board
- Lloydminster Emergency Care Services
- Manning General Hospital
- Medicine Hat City Police
- Mannville Municipal Hospital District No. 1
- Mountain View Health Care Centre, Didsbury
- NAIT, Medical Sciences Department
- Nanton, Town of
- Newell No. 4, County of
- Omnicare Ambulance, Division of Smoky Lake and District Ambulance Service Ltd.
- Paintearth No. 18, County of — Castor
- Parkland Ambulance Authority
- Peace River, Town of
- Ponoka No. 3, County of
- Provost Municipal Health Care Service, Ambulance Service
- Raymond and District Ambulance Authority
- Red Deer, City of
- Red Deer County Council Ambulance Committee
- Rocky Mountain House General Hospital
- Rural Health Care Association of Alberta
- Sacred Heart Health Centre, McLennan
- Scott, Earl J., Former Hospital Administrator, Cardston
- Sexsmith, Town of
- Slave Lake General Hospital and Ambulance Service
- Southern Air Transport Association
- Spruce Grove, City of
- St. Michael's Hospital, Lethbridge
- St. Paul General and Auxiliary Hospital and Nursing Home District #36
- Strathcona County
- Sturgeon General Hospital, St. Albert
- Sturgeon No. 90, M.D. of Morinville
- Sylvan Lake, Town of
- Taber and District Health Care Complex
- Thickwood Heights Family Medicine Clinic, Fort McMurray
- Transport Canada, Air, Western Region, Edmonton
- Tri-County Emergency Medical Services, Leduc
- University of Alberta Hospitals
- Wainwright No. 61, M.D. of
- Whitecourt, Town of

Alberta NEWS RELEASE

GOVERNMENT OF ALBERTA

RELEASE DATE: MAY 21, 1987

DEPARTMENT: POLICY ADVISORY COMMITTEE
TO THE MINISTER OF HOSPITALS AND MEDICAL CARE

SUBJECT: **PUBLIC HEARINGS SCHEDULED**
TO REVIEW ALBERTA'S AMBULANCE SYSTEM

To obtain Albertans' views, concerns and recommendations on ground and air ambulance services, 10 public hearings have been scheduled during the first week of June throughout the province by the Policy Advisory Committee to the Minister of Hospitals and Medical Care.

The Committee of M.L.A.s, health professionals and interested citizens was appointed earlier this year by the Honourable Marvin E. Moore, Minister of Hospitals and Medical Care, to provide input in policy areas. Its first task is this thorough review of Alberta's ambulance system. The Committee will focus on all aspects of ambulance services including standards, communications systems and funding in order to develop recommendations for the Minister's consideration. The Committee's recommendations are expected by the end of 1987.

The public hearings are but one aspect of the study. Also involved are detailed questionnaires to a sampling of frequent users of ambulance services such as municipalities, hospitals, lodges and nursing homes, and to those providing ambulance service. The committee will also be meeting later in June with the major "stakeholders", which include associations such as the Alberta Ambulance Operators Association, the Alberta Hospital Association, and the Alberta Medical Association. Reviews of other provincial systems are also being conducted.

The Committee will hold the public hearings simultaneously in northern and southern Alberta, with five committee members at each hearing.

NORTHERN ALBERTA SCHEDULE

June 1

Grande Prairie - Trumpeter Motor Inn
12102 - 100 Street
Richmond Room
10 a.m. - 12 noon

High Level - Royal Canadian Legion Hall
Upstairs Hall
3 p.m. - 5 p.m.

June 2

Hinton - Moose Lodge
158 Switzer
1:30 p.m. - 4:30 p.m.

June 3

St. Paul - St. Paul Senior Citizens Club
4809 - 47 Street
Pioneer Hall
10 a.m. - 1 p.m.

June 4 and 5

Edmonton - Northlands Agricom
Borden Park Road and 73 Street
Silver Slipper - south end of Northlands grounds, east of racetrack
9 a.m. - 5 p.m. Thursday
9 a.m. - 3 p.m. Friday

Hearing Chairman in the north will be Stan Schumacher, M.L.A. Drumheller, with Committee members: Jim Cawsey, Drumheller; Sid Wallace, Calgary; Nomi Whalen, Calgary; and Susan Green, Edmonton.

SOUTHERN ALBERTA SCHEDULE

June 1

Coronation - Elks Community Hall
Royal Street
10 a.m. - 3 p.m.

Red Deer - G. H. Dawe Community School
56 Holt Street
7 p.m. - 10:00 p.m.

June 2 and 3

Calgary - Sheraton Cavalier
2620 - 32 Avenue N.E.
Sheraton South Room
10 a.m. - 5 p.m. Tuesday
9 a.m. - 12 noon Wednesday

June 4

Lethbridge - El Rancho Convention Centre
526 Mayor Magrath Drive
Carolina Room
9 a.m. - 4 p.m.

June 5

Medicine Hat - Medicine Hat Lodge Hotel
and Convention Centre
1051 Ross Glen Drive S.E.
Saamis "A" Room
9 a.m. - 4 p.m.

Hearing Chairman in the south will be Halvar Jonson, M.L.A. Ponoka-Rimbey, with Committee members: Ken Mark, Edmonton; Douglas Tien, Camrose; Gerry Hachey, Palher; and Adelaide Davis, Medicine Hat.

To help individuals or groups in scheduling and for hearing planning, those making a presentation can contact Susan Green, senior policy advisor to the Minister, Alberta Hospitals and Medical Care, at 427-6085. Individuals who wish to make a verbal presentation may also advise organizers at the time of each hearing.

All written submissions to the Committee close June 15, 1987.

- 30 -

Reference: Susan Green, 427-6085.

Alberta Hospitals and Medical Care
Policy Advisory Committee
Ambulance Delivery System

"Consumer" Questionnaire

NAME OF ORGANIZATION _____

NAME _____

POSITION TITLE _____

BUSINESS TELEPHONE NUMBER _____

The Alberta Hospitals and Medical Care Policy Advisory Committee is conducting a study assessing your views and opinions on Alberta's current Ambulance Delivery System. Prior to receiving this questionnaire, you will have received correspondence indicating that a study on ambulance services is being conducted. We feel that your input is extremely important in this process. If you have any questions regarding the questionnaire or have problems in understanding any of the questions, please do not hesitate to call Susan Green at 427-7117. Please return the completed questionnaire by May 29, 1987 in the enclosed, self-addressed stamped envelope.

SECTION I — SCOPE OF SERVICE

A. Please indicate the name of the organization in your community presently providing ambulance services to you.

_____

Don't know _____

B. Has your organization ever utilized this (these) ambulance service(s)?

_____ Yes
_____ No

C. Was your organization satisfied with the services provided/received?

_____ Yes
_____ No
Please expand on your response. _____

_____

D. Is your organization aware of the levels of ambulance service available in your community?

_____ Yes
_____ No
Please check the services available in your community.
_____ E.R.U.*
_____ B.L.S.**
_____ A.L.S.***

* E.R.U. — Emergency Response Unit: means an ambulance staffed with a minimum of one person who holds a valid and subsisting St. John Ambulance Standard First Aid Certificate or equivalent.

** B.L.S. — Basic Life Support: means an ambulance which is staffed with the minimum of one Emergency Medical Technician — Ambulance (240-hour College Training Program).

*** A.L.S. — Advanced Life Support: Means an ambulance which is staffed with a minimum of one Emergency Medical Technician — Paramedic (2-year College Training).

E. Does your organization believe that the level of service available in your community is adequate to meet your needs?

_____ Yes
_____ No
Please explain your response _____.

F. Is your organization satisfied with the current rates charged for ambulance services in your community?

_____ Yes
_____ No
Please comment on your answer. _____ _____

_____

G. How does your organization access ambulance services in your community?
(Please explain) _____

H. From your point of view, what are the strengths and weaknesses of the ambulance program serving you?
Strengths: _____
_____
Weaknesses: _____
_____
Suggestions for Improvement: _____
_____
Not applicable _____

I. Indicate (x) all the services that you feel should be provided to your organization or community by an ambulance program.
_____ E.R.U.
_____ B.L.S.
_____ A.L.S.
_____ Other (please specify)_____

J. Is your community/organization serviced by air ambulance?
_____ Yes
_____ No

SECTION II — RESOURCES

A. Indicate the resources you have in your organization to perform patient care support in the delivery of ambulance service (ie. medical escort). (Frequency can be noted as weekly, monthly, quarterly, twice a year, yearly.)

1. Staff: (If not applicable, please indicate n/a___)

Type	Number	Qualifications
_____	_____	_____
_____	_____	_____

Additional Comments: _____

2. Portable Equipment: (If not applicable, please indicate n/a___)

Types	Number	Inspection Procedures (Frequency/By Whom)
_____	_____	_____/_____
_____	_____	_____/_____
_____	_____	_____/_____

Additional Comments: _____
_____

3. Transportation Equipment: (If not applicable, please indicate n/a____)

Types	Number	Inspection Procedures (Frequency/By Whom)
_____	_____	_____/_____
_____	_____	_____/_____
_____	_____	_____/_____

Additional Comments: _____

_____

4. Communication Equipment: (If not applicable, please indicate n/a___)

Types	Number	Inspection Procedures (Frequency/By Whom)
_____	_____	_____/_____
_____	_____	_____/_____
_____	_____	_____/_____

Additional Comments: _____

_____

SECTION III — PROTOCOLS

A. List the clinical protocols (procedures) and administrative procedures your organization or community employs when handling ambulance transports. If there is not enough space provided, please attach a copy of the table of contents or use the reverse side of this page.

_____

_____

B. Do you utilize dispatch protocols?

_____ Yes

_____ No

If yes, what are they? _____

_____

C. Do you feel there would be merit in developing standardized provincial protocols?

_____ Yes

_____ No

Why or why not? _____

_____

SECTION IV — INTEGRATION AND CO-ORDINATION

A. Does your facility, organization or community presently have any liaison or communication with other agencies that provide ambulance services?

_____ Yes

_____ No (go to question B)

If yes, please list what agencies you have communication with and the reasons for this communication.

Agencies	Reasons for Communication
_____	_____
_____	_____
_____	_____

B. Do you feel there is an overlap of ambulance services?
_____ Yes
_____ No
If so, how would you improve the system to avoid overlap?
_____
_____
_____

C. Would your organization be willing to become involved with developing coordination mechanisms to facilitate improved ambulance services in your community. Would you become involved with:
Management committees
_____ Yes
_____ No
Joint training of ambulance personnel
_____ Yes
_____ No
Sharing of equipment
_____ Yes
_____ No
Other (please specify)_____
_____ Yes
_____ No
Other (please specify)_____
_____ Yes
_____ No
Other (please specify)_____
_____ Yes
_____ No

D. What is your role in the local disaster services plan, if any?
_____
_____

E. From your perspective, are there any areas of dispute between agencies providing ambulance service?
_____ Yes
_____ No
If yes, what would you recommend to improve the system?

SECTION V — COSTS/FUNDING

A. What was the total cost in the 1986 calendar year, your organization or community spent on ambulance services?
$_____

B. If applicable, what are your coverage costs per trip?
$_____ per ground trip
$_____ per fixed wing trip
$_____ per helicopter trip
_____ not applicable

C. What percentage of total costs for transport is used for interhospital transfers?

Ground Ambulances	_____%
Air Ambulances	_____%
Other (please specify) _____	_____%
Other (please specify) _____	_____%
	100%

SECTION VI — EVALUATION

A. As a consumer of ambulance services, do you have any input on evaluating services rendered?

_____ Yes _____ No

If yes, please describe the procedure(s)

_____

_____

B. How do you access the system? (indicate [x] all that apply.)

_____ Emergency telephone number
(What is the emergency telephone number _____)
_____ Operator assistance
_____ Telephone ambulance
_____ Other (please specify) _____
_____ _____
_____ _____

C. Rank in order the criteria you would use to evaluate ambulance service in your community (1 being the most important).

_____ Response time from time call is received to arrival of vehicle on the scene.
_____ Costs of operation.
_____ Reduced mortality.
_____ Reduced medical complications.
_____ Other (please specify)_____

ADDITIONAL COMMENTS/RECOMMENDATIONS

Please use the space provided below to make any additional comments and/or recommendations.

Your participation in this study is greatly appreciated!
Please return the completed questionnaire by May 29, 1987.

THANK YOU!

Alberta Hospitals and Medical Care
Policy Advisory Committee
Ambulance Delivery System
Provider Questionnaire

NAME OF ORGANIZATION: _____

PERSONS COMPLETING QUESTIONNAIRE:

NAME	TITLE	BUSINESS PHONE NO.

The Alberta Hospitals and Medical Care Policy Advisory Committee is conducting a study assessing your views and opinions on our current Ambulance Delivery System. Prior to receiving this questionnaire you have received correspondence indicating that a study is being conducted. We feel that your input is extremely important. If there are questions or sections of the questionnaire that you are unable to answer, please forward the questionnaire to the appropriate person(s) in your organization. If you have any questions regarding the questionnaire or have problems in understanding any of the questions, please do not hesitate to contact Susan Green at 427-7117. Please return the completed questionnaire by May 29, 1987 in the postage-paid envelope that has been provided.

SECTION I — SCOPE OF SERVICES

A. What is your agency's defined area of coverage for ambulance services?

1 to 50 miles _____
51 to 100 miles _____
101 to 500 miles _____
501 to 1000 miles _____
1001 miles or more _____

If you have a map of your area of coverage, please attach.

B. Does your area of coverage overlap with any other jurisdiction?

_____ Yes
_____ No (Go to question C)
If so, please specify _____ _____
_____ _____

Does this create a problem?

_____ Yes
_____ No
Please explain _____
_____

C. What recommendations do you have to improve the co-ordination of ambulance services across geographical boundaries?

_____

D. What service(s) does your agency provide? [Please indicate (x) all appropriate service(s)]

Primary Emergency Response _____
Extrication (Rescue) _____
Emergency Response Unit _____
Basic Life Support _____
Advanced Life Support _____
Patient Transfers _____
Interhospital Transfers _____
Interprovincial Transfers _____
Out of Country Transfers _____
Other (Please Specify) _____

E. Please indicate (x) if your ambulance program is presently governed by: (If no, go to Section II.)

Municipal Bylaws	_____
Formal Agreements	_____
Contracts	_____
Other (Please specify)	_____

If yes, please attach a copy or copies.

Please define any area of legislation that is problematic for you.

i) Provincial _____

_____

_____

ii) Municipal _____

_____

_____

iii) Please define any area of contractual agreement that is problematic for you

_____

_____

_____

What changes would you recommend to rectify the problem or problems?

i) Provincial _____

_____

_____

ii) Municipal _____

_____

_____

iii) Contractual _____

_____

_____

SECTION II — UTILIZATION

A. Please provide a breakdown of the utilization (number of cases) of your agency's ambulance program by source, in the 1986 calendar year.

	Number of Cases
Highway	_____
Industrial	_____
Rural	_____
Interhospital Transfer	_____
Other (Please Specify)	_____
TOTAL _____	

SECTION III — RESOURCES

A. Please attach an Organizational Chart of your agency's ambulance services division.

B. Please comment on the type and degree of involvement of physicians in your agency's ambulance program.
   i) Type of involvement _____
   _____
   _____
   ii) Degree of involvement _____
   _____
   _____

C. What is your local medical authority's area of medical specialty?
   _____
   _____

D. Please provide a description of staff performing ambulance services.

Type of Staff	Number of Staff	Male	Female
EMT-P	_____	_____	_____
EMT-A	_____	_____	_____
First Aider	_____	_____	_____
R.N.	_____	_____	_____
Other	_____	_____	_____
(Please specify)	_____		

E. Please list the activities of the ambulance members when on duty but not performing ambulance services.
   _____
   _____

F. Please attach a list, or describe below, clinical portable equipment used by your agency.
   Quantity Type and Specification
   _____ _____
   _____ _____

G. Please provide a list, or describe below, ambulance vehicles used in your operation.

Type of Vehicle	Quantity
Modular Van_____	_____
Raised Van	_____
Suburban	_____
Other (please specify)	_____

   _____

H. Do your vehicles meet Alberta Ambulance Operators Association standards?
   _____ Yes
   _____ No

I. In general, what is the life expectancy of your present ambulance vehicles?

Type of Vehicle	Life Expectancy (in months)
Modular	_____
Van_____	
Raised Van	_____
Suburban	_____
Other (Specify)	_____

J. From your perspective, please comment on the present radio communication system between and among emergency service in Alberta.

_____

_____

What are your suggestions for improvement?

_____

_____

K. Do you utilize a common radio frequency with other agencies in time of emergency?

_____ Yes (Please describe below)

_____ No

_____

_____

L. Please indicate the existence of and provide a description of the physical facilities that house your agency's ambulance teams and their equipment.

Is there a designated office?

_____ Yes (please describe below)

_____ No

_____

_____

Are there sleep-over facilities?

_____ Yes (please describe below)

_____ No

_____

_____

Are there designated areas for storage of portable clinical equipment and supplies?

_____ Yes (please describe below)

_____ No

_____

_____

Are there designated areas for storage of ambulances, ie. garage space?

_____ Yes (please describe below)

_____ No

_____

_____

Is there jurisdiction over space and equipment away from base of operations?
_____ Yes
_____ No
_____
_____

Is someone responsible for servicing ambulances?
_____ Yes
_____ No If yes, how often
_____
Please describe _____
_____

Are ambulance services located at hospital?
_____ Yes (please describe below)
_____ No
_____
_____

M. What would you suggest to improve the condition of your physical facilities for ambulance teams and their equipment?
i) For teams _____
_____
_____
ii) For equipment _____
_____
_____

SECTION IV — PROTOCOLS

A. Does your agency have a list of clinical protocols used by your agency's ambulance service?
_____ Yes
_____ No (go to question H)

B. When were these protocols last updated?
_____ (month and year)

C. Were these clinical protocols developed solely by your service?
_____ Yes
_____ No
If no, by whom?_____

D. Are they a standardized set of protocols developed by another ambulance service?
_____ Yes
_____ No

E. Do the protocols have input from medical staff?
_____ Yes
_____ No

F. Were the protocols approved by medical staff?
_____ Yes
_____ No
Please attach a list and description of these protocols.

G. Do you feel there would be merit in developing standardized provincial protocols?
_____ Yes
_____ No
Why or why not? _____
_____

H. What are your recommendations for improvements to clinical protocols?
i) For your ambulance service _____
_____
ii) For provincial protocols _____
_____

I. Does your agency use dispatch protocols?
_____ Yes
_____ No (go to next section)
If yes, please attach a copy.

J. Were there protocols developed by you for your particular service?
_____ Yes
_____ No If yes, by whom?_____

K. Do you feel there would be merit in developing standardized provincial dispatch protocols?
_____ Yes
_____ No

L. What are your recommendations for improvements to dispatch protocols?
_____
_____

SECTION V — INTEGRATION AND CO-ORDINATION

A. Please provide a list of agencies that form a network of integration, cooperation and mutual support for ambulance services in your region.
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
If not enough space has been provided, please use back side of this page.

B. Does your agency have a clear idea of its respective role and responsibility for ambulance service in terms of other services' respective roles, for example, hospital, fire, police?

_____ Yes
_____ No

Why or why not? _____
_____
_____
_____

C. Are guidelines of respective roles and responsibilities for ambulance service written down and circulated to all related services, for example, hospital, fire, police?

Written		Circulated	
_____	Yes	_____	Yes
_____	No	_____	No

D. Does your agency take part in formal communications for co-ordinating ambulance services?

_____ Yes
_____ No

E. Do you feel there is duplication of service?

_____ Yes
_____ No

If yes, please specify how you would improve the system to avoid duplication.

_____
_____

F. Does your agency have shared training programs for ambulance services with other services?

_____ Yes
_____ No

Why or why not? _____
_____

G. Does your ambulance service share equipment with other ambulance services, fire departments, hospitals or others (please specify)?

Ambulance Services		Fire Departments		Hospitals		Other	
_____	Yes	_____	Yes	_____	Yes	_____	Yes
_____	No	_____	No	_____	No	_____	No

Why or why not? _____
_____
_____

Please indicate the type of equipment shared. _____
_____

H. *If there is no* formal communication (answers of No from C to F), are there co-ordination mechanisms between services such as telephone calls, informal meetings, etc.?

_____ Yes
_____ No

If yes, please specify the types of communications.

_____
_____

I. What is your service's role in your local disaster services plan?

_____
_____

J. From your perspective, are there any current "areas of dispute" as described below between agencies providing ambulance services?

1. Duplication/Overlap
   _____Yes
   _____No
2. Poor Co-ordination/Liaison
   _____Yes
   _____No
3. Poor Liaison
   _____Yes
   _____No
4. Other (Specify)
   _____
   _____Yes
   _____No

What would you recommend to improve the integration and co-ordination between services?

_____
_____

SECTION VI — COSTS/FUNDING

A. Please provide a cost breakdown of operational costs for the 1986 calendar year and projections for 1987, for your ambulance program.

	1986	1987
Staffing		
- Management	_____	_____
- Ambulance Attendants	_____	_____
- Ambulance Drivers	_____	_____
- Communications	_____	_____
- Clerical	_____	_____
- Training others (Specify)	_____	_____
- Other (Please specify)	_____	_____
_____		
Staffing Benefits	_____	_____
Supplies and Services	_____	_____
Equipment	_____	_____
Buildings	_____	_____
Other Expenses (Specify)	_____	_____
_____		
Total Cost	_____	_____

B. What are the operating costs per case in the 1986 calendar year and projected costs for the 1987 calendar year using the equation below?

			1986	1987
Total Cost / Total # of Cases	=	Average Cost/Year	_____	_____

C. Please provide a breakdown of capital costs.

1. Equipment/Vehicles	- Actual 1986	$_____
	- Projected 1987	$_____
2. Buildings	- Actual 1986	$_____
	- Projected 1987	$_____

D. What is the amount and percentage of funding by source for your ambulance program? Use the 1986 calendar year or, if not possible, 1985, as a "bench mark."

Federal Government	$_____	_____%
Provincial Government	$_____	_____%
Municipal Government	$_____	_____%
Patient's Employer	$_____	_____%
Alberta Blue Cross	$_____	_____%
Private Patient Insurance	$_____	_____%
Workers' Compensation Board	$_____	_____%
Hospital	$_____	_____%
Other (Please specify)	$_____	_____%
_____		
TOTAL $_____		100%

Based on 19___ data

SECTION VII — EVALUATION

A. Does your service routinely conduct:

	YES	NO	BY WHOM	FREQUENCY
Medical Audit	____	____	_____	_____
Supervisory Audit	____	____	_____	_____
Patient Care Audit	____	____	_____	_____
Others (please specify)				
_____	____	____	_____	_____
Does your service routinely inspect:				
Equipment including trauma kits	____	____	_____	_____
Drugs	____	____	_____	_____
Others (please specify)				
_____	____	____	_____	_____
_____	____	____	_____	_____

B. Were these audit and inspection procedures developed for your particular service?

_____ Yes
_____ No (go to question C)

If yes, how long have these procedures been utilized?
_____ Months
_____ Years

How often are these procedures updated?
_____ Months
_____ Years

Please provide a copy of the evaluation tool(s).

C. Is there a formal feedback evaluation mechanism between your service and other services performing ambulance services?
_____ Yes
_____ No (go to the next question)
Please describe _____
_____

D. Is there a formal feedback evaluation mechanism between your service and the consumer (patient or client) of ambulance services?
_____ Yes
_____ No (go to the next question)
Please describe _____
_____
_____

E. Is there a staff evaluation program in your ambulance program?
_____ Yes
_____ No (go to the next question)
Please describe _____
_____
_____

F. Is there a staff upgrading program in your ambulance program?
_____ Yes
_____ No (go to the next question)
Please describe _____
_____
_____
_____

G. Is there a formal mechanism for recording trips for services provided?
_____ Yes
_____ No
If yes, please attach a copy of your trip report form.

H. Is there a formal mechanism for recording patient care services provided?
_____ Yes
_____ No (go to question J)
If yes, please attach a copy of your patient care report.

I. Whom is patient care report distributed to?
_____

J. Would you like to see a standardized province-wide patient care report form developed?

_____ Yes
_____ No

If yes, what are your suggestions regarding format, content and distribution.

_____
_____
_____

Additional Comments/Recommendations

Please use the space provided below to make any additional comments and/or recommendations.

Your participation in this study is greatly appreciated!
Please return the completed questionnaire by May 29, 1987.

Thank you.

ORGANIZATIONAL CHARTS

Appendix 3 contains organizational charts depicting the structure of the five provincial ambulance systems. These charts identify the broad responsibility areas in each system rather than illustrating individual job positions.

The Policy Advisory Committee, during completion of this report, considered the components required to provide effective delivery of ambulance services for a province-wide system. This consideration led to the development of a proposed organizational structure for Alberta's Ambulance Services Commission. The broad responsibilities of the Commission have been identified in the attached organization chart (Figure 2).

Figure 1

DEPARTMENT OF HOSPITALS AND MEDICAL CARE
ALBERTA

PRESENT STRUCTURE (AIR AMBULANCE PROGRAM)

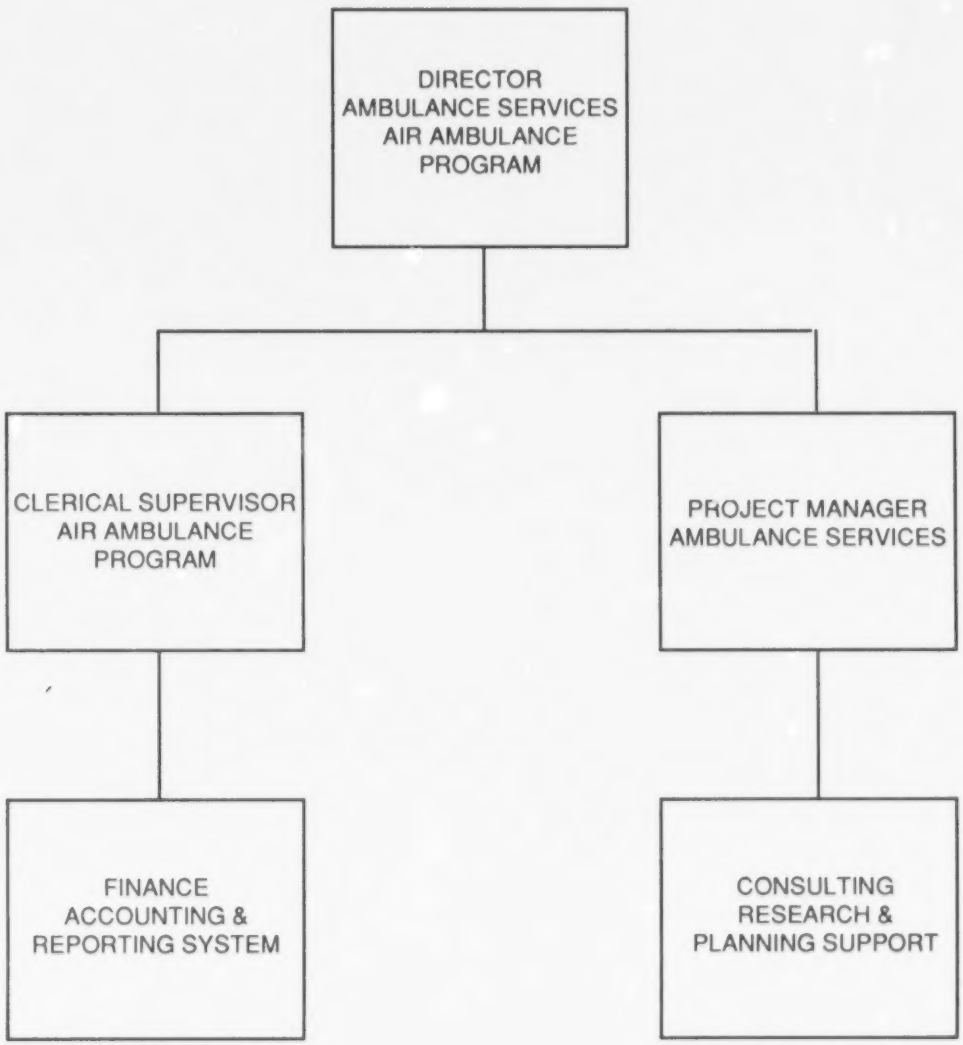


Figure 2

PROPOSED AMBULANCE SERVICES COMMISSION

ALBERTA

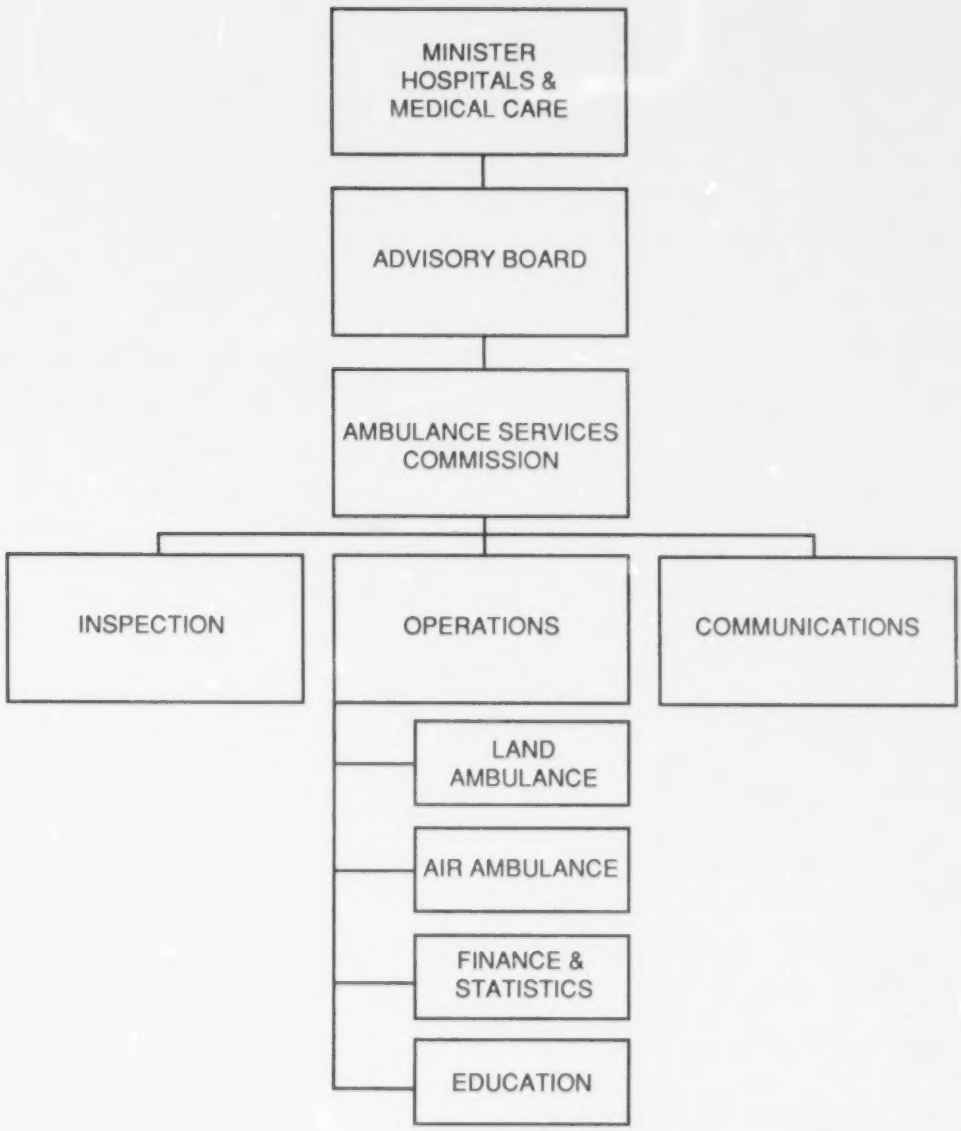


Figure 3

EMERGENCY HEALTH SERVICES COMMISSION

BRITISH COLUMBIA

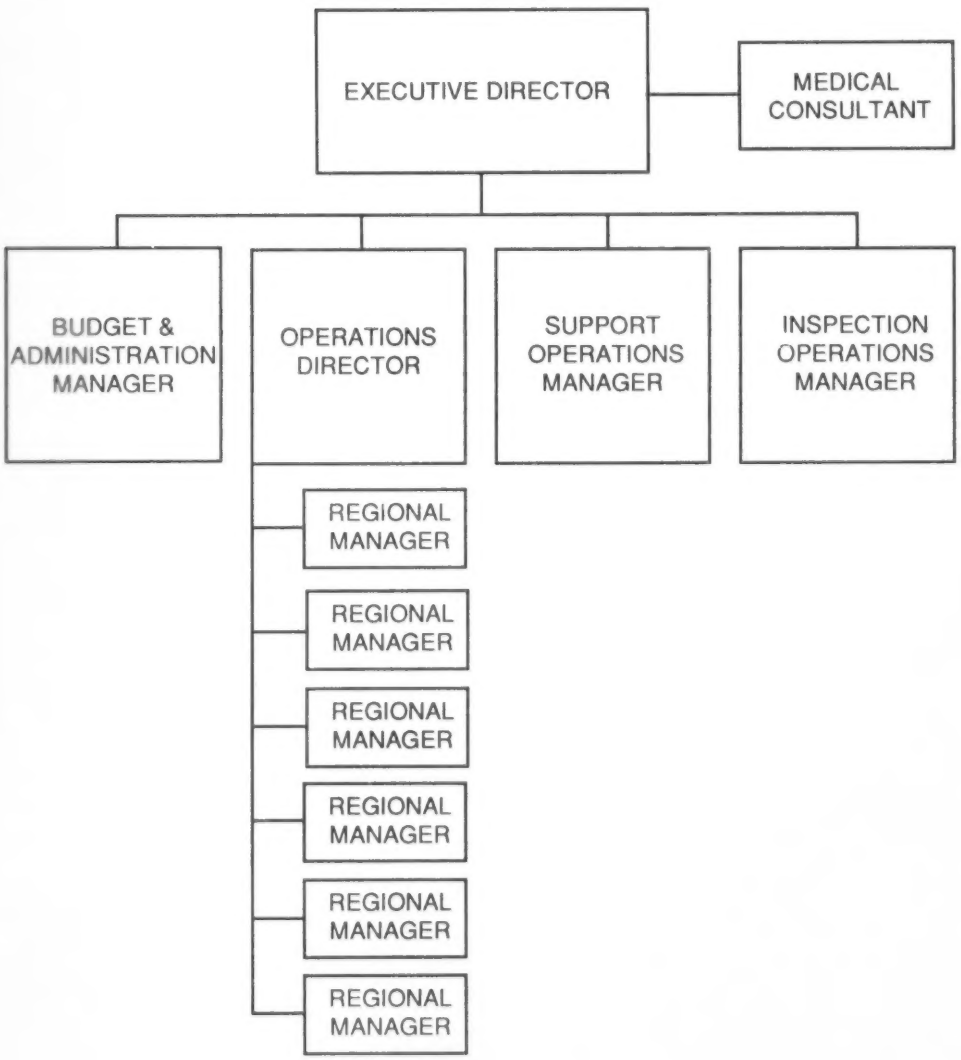


Figure 4

AMBULANCE SERVICES UNIT

DEPARTMENT OF HEALTH
SASKATCHEWAN

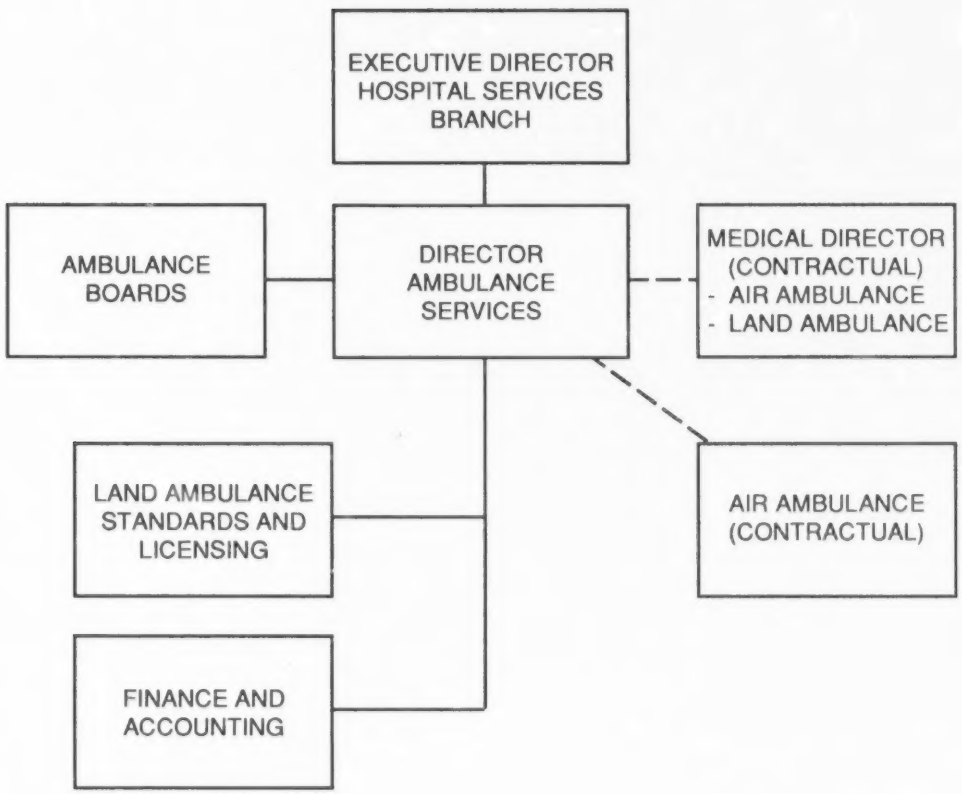


Figure 5

EMERGENCY AND AMBULANCE SERVICES DIVISION

HEALTH SERVICES COMMISSION
MANITOBA

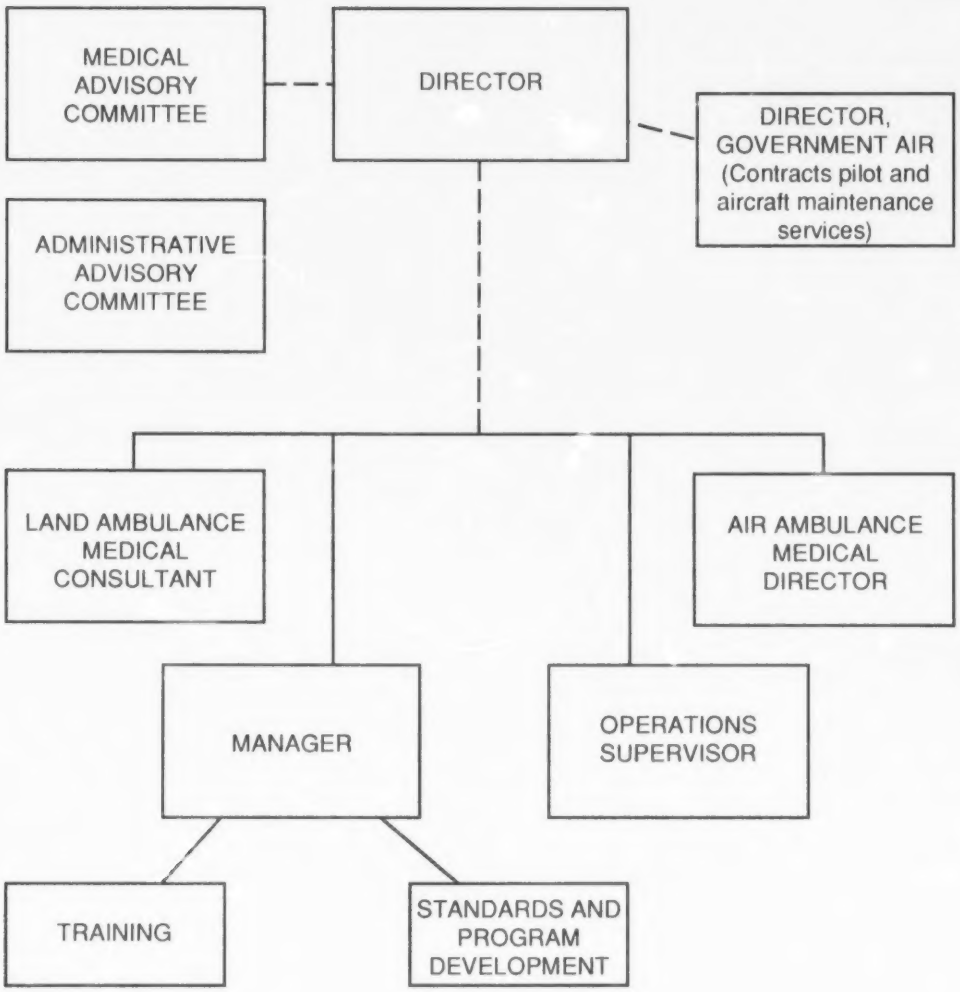
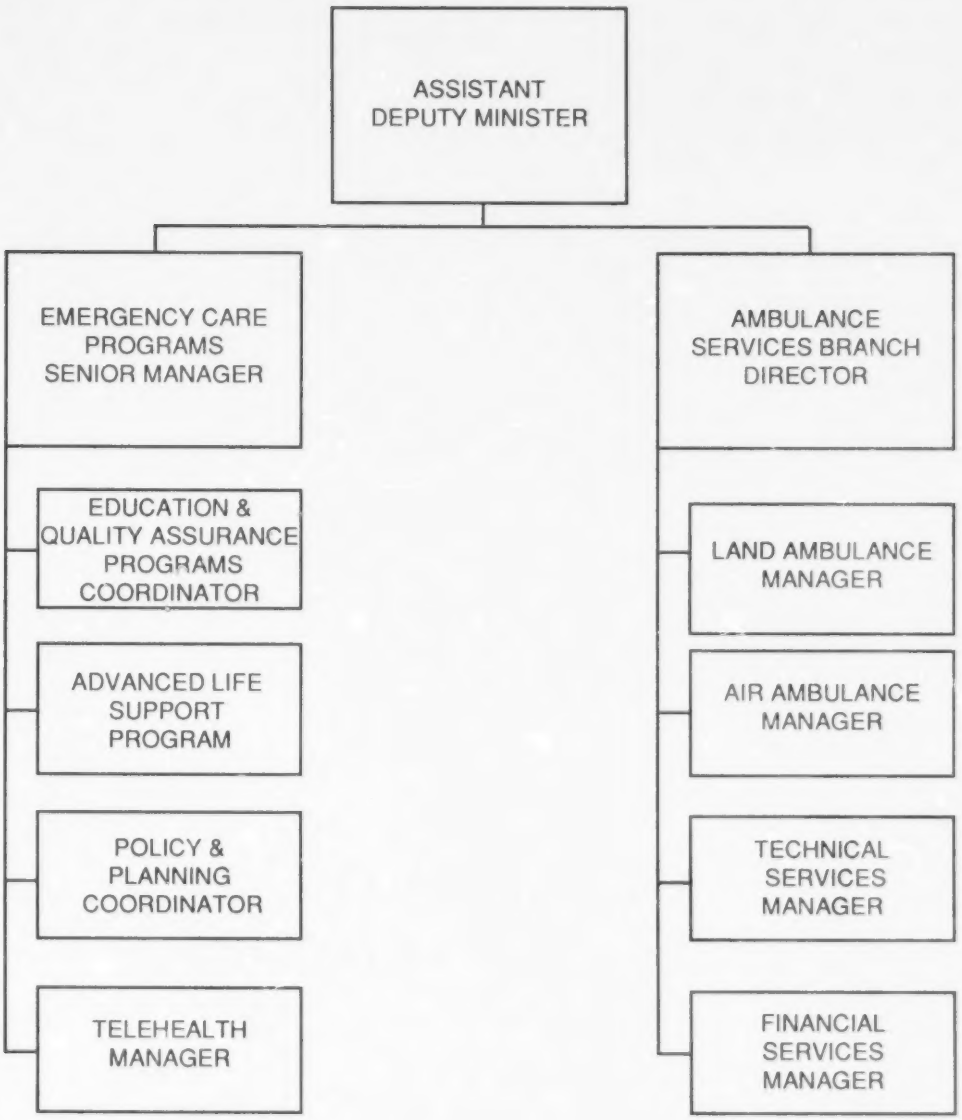


Figure 6

EMERGENCY AND SPECIAL HEALTH SERVICES

MINISTRY OF HEALTH
ONTARIO



ALBERTA AMBULANCE OPERATORS ASSOCIATION MEMBERSHIP

March, 1988

Title	Location	Level
Aaron Paramedical	Calgary	ALS/BLS
Aeromedical Emergency Services	High Level	ALS/BLS
Airdrie Fire Department	Airdrie	ALS
Alberta Med-E-Vac	Oyen	ALS/BLS
Alberta North Star Ambulance	Two Hills	BLS/ERU
Ambucare Emergency Medical Service	Ponoka	ALS/BLS
Archer Memorial Hospital Community Ambulance Service	Lamont	ERU
Associated Ambulance & Services	Mayerthorpe	ALS/BLS
	Strathmore	ALS
Athabasca Ambulance Service	Whitecourt	BLS
Barrhead Ambulance Service	Athabasca	BLS
Bassano Ambulance Service	Barrhead	ALS/BLS
Beaver Ambulance Service	Bassano	ERU
Beaver Ambulance Service	Tofield	BLS
Bentley Fire Department and Ambulance Service	Viking	BLS
Blood Tribe Ambulance Service	Bentley	ERU
Bonnyville Municipal Ambulance	Standoff	ERU
Bow Valley Ambulance Service	Bonnyville	BLS
Boyle and Dstrict Ambulance	Canmore	ALS/BLS
Brooks & District Ambulance	Boyle	BLS
Bud's Ambulance Service	Brooks	BLS
Calgary EMS Department	Valleyview	ERU
Camrose City/County Ambulance	Calgary	ALS
Cardston Municipal Hospital Ambulance	Camrose	BLS
Caroline District Ambulance	Cardston	BLS
Central Peace Ambulance	Caroline	BLS
Chinook Emergency Services Ltd.	Spirit River	BLS
Town of Coaldale Ambulance	Claresholm	BLS
Cochrane Ambulance Service	Coaldale	BLS/ERU
Cold Lake Hospital Ambulance	Cochrane	ALS/BLS
Devon Emergency Medical Services	Cold Lake	BLS
Drayton Valley Ambulance	Devon	BLS
Drumheller Area Ambulance	Drayton Valley	BLS
East Central Ambulance Association	Drumheller	BLS
Eckville & District Ambulance	Castor	ERU
Edmonton Ambulance Authority	Eckville	BLS
Elk Point & District Ambulance	Edmonton	ALS/BLS
Emergency Medical Services Beaverlodge/Hythe	Elk Point	BLS/ERU
Fairview & District Ambulance	Beaverlodge	BLS
Flagstaff County Ambulance	Fairview	BLS
Foremost Volunteer Ambulance	Sedgewick	ERU
Fort Macleod Ambulance Service	Foremost	ERU
Fort McMurray Fire Department	Fort Macleod	ERU
Gleichen-Blackfoot Ambulance	Fort McMurray	ALS
Grande Cache Ambulance	Strathmore	BLS
Grande Prairie Ambulance	Grande Cache	BLS
	Grande Prairie	ALS

Grimshaw/Berwyn & District Ambulance	Grimshaw	BLS/ERU
Guardian Ambulance	Innisfail	ALS
Hanna Ambulance Service	Hanna	BLS
High Prairie Regional Health Complex	High Prairie	BLS
High River District Ambulance	High River	ALS/BLS
Hinton Ambulance Ltd.	Hinton	BLS
Innisfail & District EMS	Innisfail	ALS/BLS
Jesperson Ambulance Service	Fox Creek	ERU
Kneehill Ambulance Service	Linden	BLS/ERU
Lac La Biche & District Ambulance	Lac La Biche	BLS/ERU
Lacombe Municipal Ambulance	Lacombe	ALS/BLS
La Crete Ambulance Society	La Crete	ERU
Lakeland Ambulance Service	Two Hills	BLS
	Willingdon	
	Vegreville	
	Islay	
	Saddle Lake #125	
Lethbridge Fire Department Ambulance Service	Lethbridge	ALS/BLS
Lloydminster Emergency Care Service	Lloydminster	ALS/BLS
Manning General Hospital	Manning	BLS
Medicine Hat Ambulance Service	Medicine Hat	ALS
Mobil Care Ambulance	Wabamun	BLS
Morinville & District Ambulance	Morinville	BLS/ERU
Mountain View Ambulance	Didsbury	BLS
Muskwachees Ambulance Authority	Hobbema	ALS/BLS
Nanton Ambulance Service	Nanton	BLS/ERU
Noralta Taxi and Ambulance Service	Smith	ERU
Oilfields Ambulance Service	Turner Valley	BLS
Olds Ambulance Service	Calgary	BLS
Omnicare Ambulance	Smokey Lake	BLS
	Redwater	
	Radway	
	Vilna	
Parkland Ambulance Authority	Stony Plain	ALS/BLS
	Spruce Grove	
	Onoway	
	Wabamun	
	Alberta Beach	
Peace River Ambulance Service	Peace River	BLS
Pigeon Lake Emergency Service	Mulhurst	BLS/ERU
Pincher Creek Fire Department	Pincher Creek	BLS/ERU
Provost Municipal Health Care Centre Ambulance Service	Provost	BLS/ERU
Rainbow Lake Ambulance	Rainbow Lake	ERU
Raymond & District Ambulance	Raymond	ERU
Red Deer Fire Department	Red Deer	ALS
Richard's Ambulance Service	Rimbey	ERU
Rocky Ambulance Service	Rocky Mountain House	BLS
Rocky Mountain APC & Ambulance Corp	Jasper	ALS
Slave Lake Ambulance Service	Slave Lake	ALS/BLS/ERU
Smoky River Ambulance Service	McLennan	BLS/ERU
St. Albert Ambulance Service	St. Albert	ALS/BLS
St. John Ambulance Sturgeon Area Br.	Bon Accord	ERU

St. Paul & District Ambulance	St. Paul	BLS
Stettler & District Ambulance	Stettler	BLS
Strathcona County Fire Department	Sherwood Park	ALS
Sundre & District Ambulance	Sundre	BLS
Superior Ambulance Service	Fort Saskatchewan	BLS
Sylvan Lake EMS	Sylvan Lake	BLS/ERU
Taber & District Ambulance	Taber	ERU
Tri-County EMS Ltd.	Leduc	BLS
Vermilion Valley Ambulance	Vermilion	BLS/ERU
Vulcan Ambulance Service	Vulcan	ERU
Wainwright & District Ambulance	Wainwright	BLS
W.D. Ambulance Service	Wabasca	ERU
Weller Medical Systems	Calgary	ALS
Westlock Ambulance Service	Westlock	BLS
Wetaskiwin Hospital Ambulance	Wetaskiwin	BLS
Yellowhead Ambulance Service	Edson	BLS/ERU
Wheatland & Adjacent Districts EMS Association	Strathmore	ALS

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